MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1340 05119

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:
County: Montg, Co,
City or town: Gaithersburg. Md,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr 11 Mo
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Annie Elizabeth Adamson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Ronald J, Adamson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 25th 1863

8. AGE: Years	Months	Days	If less than one day
1863 84	2	11	....hrs. ....min.

9. Birthplace: Manassas, Va,
(Town, county, and state)
10. Usual occupation: House Wife,
11. Industry or business: "

FATHER
12. Name: Robert B. Merchant
13. Birthplace: Va,

MOTHER
14. Maiden name: Alice Morgan
15. Birthplace: Va,

16. Informant: Rev, H M Wilson, Methodist Home
Address: Gaithersburg. Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/9/47 (month) (day) (year)
Cemetery or crematory: Manassas Cemetery
Location: Manassas Va,

18. Funeral director: Ernest C, Gartner
Address: Gaithersburg. Md,

19. June 7 1947 Ahmad G Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6th 1947 at 7 Pm M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June - 5 - 1947 to June - 6 - 1947 and that I last saw her alive on June - 6 - 1947

Immediate cause of death	DURATION
Stone in pelvis of kidney - Obstructed uretes - left kidney	36 hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: William E. Miller M.D.
M. D. or other
Address: Gaithersburg, Md Date signed 6/9/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05120

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville (or R.F.D.)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs 6 mo
Hospital, Institution, or street address where death occured: Woodmere Sanatorium — Rockville
How long in hospital or institution? 10 years

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants give residence of mother)
State: Wash. D. C. County:
City or town: Washington D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3709 Military Rd. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs Vera Adelman

3. (b) Social Security Number:

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Arthur Adelman
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): June 25 1882
8. AGE: Years: 64 Months: 11 Days: 24 If less than one day: hrs. min.
9. Birthplace: Michigan (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER 12. Name: [illegible]
13. Birthplace: [illegible]
MOTHER 14. Maiden name: Mary Kellogg
15. Birthplace: Michigan
16. Informant: Mrs Arthur Adelman
Address: 3709 Military Rd N.W.
17. [illegible] (Burial, cremation, or removal. Which?) Date thereof: June 21 47 (month) (day) (year)
Cemetery or crematory: Rock Creek
Location: Washington D.C.
18. Funeral director: The J. H. Higgins Co.
Address: 2901 14th St. N.W.
19. 6/19/47 (Date rec'd by registrar) Wm E. Dohe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 19 1947, at 7 A.M. 45

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 19.. to June 19 1947
and that I last saw her alive on June 18 1947

	DURATION
Immediate cause of death: Myocardial failure	3 days
due to: cerebral thrombosis	
Due to:	
Due to:	
Other conditions: Arteriosclerosis, Senile dementia, Chronic arthritis	10 years

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wm. A. Smithers M.D.
M. D. or other
Address: Rockville, Md. Date signed 6/19/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05121 46d K

05121

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1707 Eye St., N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3. (a) FULL NAME: ALBEE, William Franklin

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 29 September 1882

8. AGE: Years	Months	Days	If less than one day
64	8	24	hrs. min.

9. Birthplace: Oregon (Town, county, and state)

10. Usual occupation: US Government

11. Industry or business:

FATHER

12. Name: Charles Albee dec.

13. Birthplace: Maine

MOTHER

14. Maiden name: Anna Tuttle dec.

15. Birthplace: Conn.

16. Informant: sister: Mrs. May Stanard

Address: 1707 Eye St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 6-25-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: S. H. HINES,

Address: 3901 14th St., N.W., Wash., D.C.

19. 6-23 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 23 June 19 47 at 4:20A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 June 19 47 to 23 June 19 47 and that I last saw h im alive on 23 June 19 47

Immediate cause of death	DURATION
CORONARY THROMBOSIS WITH MYOCARDIAL INFARCTION, OLD and RECENT	
Due to ARTERIOSCLEROSIS, GENERAL	
Due to	
Other conditions PULMONARY CONGESTION	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: SAME AS ABOVE WITH ADDITION OF CARCINOMA OF CECUM

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE J. B. Bryan J. B. BRYAN, Lt. (jg) (MC) USNR M. D. or other

Address: USNH Bethesda, Md. Date signed: 6-23-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

5/30/14

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05122

131a

CERTIFICATE OF DEATH

Reg. Diat. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~Usual~~ or street address where death occurred:
507 Pershing Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 507 Pershing Drive
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: MRS. JANE C. ANDERSON

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Edward S.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 19th. 1884

8. AGE: Years	Months	Days	If less than one day
62	6	28	..... hrs. ..... min.

9. Birthplace: Fort Custer, Mont.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: James Edw. Wilson
13. Birthplace: Ireland

MOTHER
14. Maiden name: Annie Ferguson
15. Birthplace: Ireland

16. Informant: Mrs. Mary E. Cummings
Address: 507 Pershing Dr. Silver Spring

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-20-1947 (month) (day) (year)

Cemetery or ~~cemetery~~: Cedar Hill

Location: Suitland, Pr. Geo's Co., Md.

18. Funeral director: James E Cumpston.

Address: Silver Spring, Maryland.

19. June 18 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17 1947, at 12 50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1943 to June 17 1947

and that I last saw h... alive on June 16 1947

Immediate cause of death: Hypertensive cardio renal-vascular disease.

	DURATION
Due to:	4 yrs
Due to:	
Other conditions: Uremia.	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Lester W. Harris M.D. M. D. or other

Address: 45 Franklin Sq. Wash DC Date signed 6-17-47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

50 +

05128 216

Reg. Dist. No.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Gaithersburg —
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 yrs
Hospital, Institution, or street address where death occurred: home - RFD #3 -
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Gaithersburg -
(If outside city or town limits, write RURAL and give nearest town)
Street No.: RFD #3, Frederick Pike —
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Bessie McGill Akundel

3.(b) Social Security Number: none —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed —

6.(b) Name of husband or wife: Victimous Akundel
6.(c) If alive, give age: Dead — years

7. Birth date of deceased (mo., day, yr.): August 5, 1887

8. AGE: Years	Months	Days	If less than one day
59	10	11	hrs. min.

9. Birthplace: Leesburg, Virginia —
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: own home —
FATHER 12. Name: John G. Utterback
FATHER 13. Birthplace: Loudon County, Virginia.
MOTHER 14. Maiden name: Ellie, Brown
MOTHER 15. Birthplace: Loudon County, Virginia —
16. Informant: Ethel Eliz. Wilson
Address: RFD #3, Gaithersburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6/19/47 (month) (day) (year)
Cemetery or crematory: Union Cemetery
Location: Leesburg, Virginia
18. Funeral director: Wm. Reuben Humphreys
Address: 7557 Wisconsin Ave., Bethesda
19. 6/17 1947 (Date rec'd by registrar) Wm Eyler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 16 1947, at 7:58 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1947, to June 16 1947 and that I last saw her alive on June 16 1947

Immediate cause of death	DURATION
Bronchopneumonia	1 day
Due to: Carcinoma of Lung	1946
Due to: Carcinoma of Breast	1943
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of breast —
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Willis Webb - M.D.
M. D. or other
Address: Rockville, Md Date signed: 6/16/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05124

120a

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days
Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Md.
How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6 Rudder Green, Southwest
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: BALBUENA, Josephine Whalen

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Pablo BALBUENA
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 18 September 1916

8. AGE: Years	Months	Days	If less than one day
30	8	13	hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Joseph Whalen
13. Birthplace: Philadephia

MOTHER
14. Maiden name: Mary Fitzpatrick
15. Birthplace: Ireland

16. Informant: Hus.: Pablo Balbuena
Address: 6 Rudder Green SW, Washington, D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6-4-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Virginia

18. Funeral director: W.W. CHAMBERS CO.
Address: 517 11th Street, SE, Wash., D. C.

19. June 1 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 June 1947, at 12:15 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 5-19 1947, to 6-1 1947
and that I last saw her alive on 6-1 1947

Immediate cause of death: Acute Ulcerative Colitis — DURATION: 5 wks
Due to: Massive hemorrhagic ulcerative colitis with overwhelming toxemia (Dr.Owens - 8-28-47) ams
Due to:
Other conditions: Bronchopneumonia / Pulmonary Edema
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results: Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J.C.OWENS, LCDR MC USN (M. D. or other)
Address: USNH, Bethesda., Md. Date signed: 6-1-47

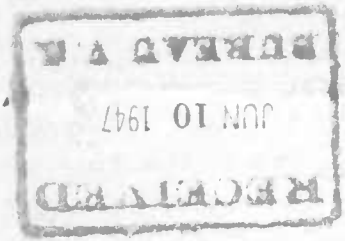
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

6/6/47

For additional inf. on cause of death see correspondence under "OWens" recd. in V.S. 8-27-47.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46d

05125

CERTIFICATE OF DEATH

Reg. Diat. No. 217

1. PLACE OF DEATH:
County Montgomery
City or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
The Montgomery County General Hospital
How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Howard
City or town Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
Street No. R # 2
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mrs. Elizabeth Bandel

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Femal	White	Married.

6.(b) Name of husband or wife Mr. John Bandel
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 17, 1869

8. AGE: Years 79 | Months 7 | Days 12 | If less than one day ..... hrs. ..... min.

8. Birthplace New York
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Mr. Henry Weber
13. Birthplace Germany

MOTHER
14. Maiden name Elizabeth Elgert
15. Birthplace Germany

16. Informant Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-2-47 (month) (day) (year)

Cemetery or crematory Westview
Location Baltimore Md
18. Funeral director H. Steinwehr Sons
Address Ellicott City Md

19 7-1 1947 Gertrude B. Lawlor
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1947, at 7 20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 16 1946 to June 29 1947
and that I last saw her alive on June 29 1947

Immediate cause of death	DURATION
Acute cardiac failure	3 hours
Due to: Myocardial insufficiency	12 hours
Due to:	
Other conditions: Carcinoma of the rectum	3 years

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of the rectum
Date of op. June 17, 47
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Charles S. Whitaker M.D.
M. D. or other
Address Charlesville, Md. Date signed .....

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05126

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 hours

Hospital, institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 5 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1916 15th Street, Southeast

(If rural, give LOCATION)

2.(a) If veteran, name war: W W I & II

3. (a) FULL NAME: BELL, John Joseph

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Helen M. Bell

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 21 October 1902

8. AGE: Years	Months	Days	If less than one day
44	7	12	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Retired Naval Personnel

11. Industry or business:

FATHER — 12. Name: Arthur Bell

13. Birthplace: Maryland, dec.

MOTHER — 14. Maiden name: Della Rowe

15. Birthplace: Maryland, dec.

16. Informant: Wife: Mrs. Helen Bell

Address: 1916 15th St., S.E., Wash., D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6-5-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Virginia

18. Funeral director: W. W. Chambers, Co. W. J. T.

Address: 517 11th St., SE, Washington, D. C.

19. 6-2 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 June 1947, at 4:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 June 1947, to 2 June 1947 and that I last saw him alive on 2 June 1947

	DURATION
Immediate cause of death: PULMONARY EMBOLISM	2-3 Days
Due to: AURICULAR FIBRILLATION	3 years
Due to: RHEUMATIC HEART DISEASE	3 years
Other conditions: CONGESTIVE HEART FAILURE	3 years

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: NOT GRANTED BY FAMILY

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J.B.BRYAN, LTJG MC USNR M. D. or other

Address: USNH, Bethesda, Md. Date signed: 6-2-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

6/10/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

469 CB

05127

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 12 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 1 month, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 112 Heckman St., S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: WWI

3. (a) FULL NAME: BEST, Joseph (n)

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	married

6.(b) Name of husband or wife: Mrs. Anne Best
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 11, 1892

8. AGE: Years	Months	Days	If less than one day
55	1	14	hrs. min.

9. Birthplace: N. C. (Town, county, and state)
10. Usual occupation: unknown
11. Industry or business

FATHER
12. Name: BEST, John dec.
13. Birthplace: N.C.

MOTHER
14. Maiden name: Maggie ? dec
15. Birthplace: N.C.

16. Informant: wife: Mrs. Anne Best
Address: 112 Heckman St., S.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 6-30-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: Robert G. Mason, K.A
Address: 2500 Nichols Ave., S.E., Wash., D.C.

19. 6-25 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 25 19 47 at 5:12 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 May 19 47 to 25 June 19 47 and that I last saw h im alive on 25 June 19 47

Immediate cause of death	DURATION
Exsanguination from bleeding duodenal ulcer	3-4 days
Due to: Duodenal ulcers (2) chronic	
Due to: Carcinoma of the head of the pancreas & obstruction of the biliary & pancreatic ducts	1 year?

Other conditions: Jaundice, cachexia, Meckle's diverticulum, serous atrophy of retroperitoneal tissues
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Statid above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul R. Engle P. R. ENGLE, Cdr. (MC) USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 6-25-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

5/5/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

836

05128

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Montgomery.
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 days
Hospital, institution, or street address where death occurred:
708 Sligo Ave.
How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 425 - 15th St. S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Minnie Virginia Brewer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Benjamin F. Brewer
6.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): Dec. 28 - 1862

8. AGE: Years: 84 | Months: 5 | Days: 18 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Frederick, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: George Lugenbeel
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Sina
15. Birthplace: Maryland

16. Informant: Beatrice B. Shropshire
Address: 120 Golfview Rd. Ardmore, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 21, 1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland - Md. Dist. Col.

18. Funeral director: James T. Ryan, Inc.
Address: 317 Pa Ave S E

19. June 18 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18 1947 at 8:50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 3 1947, to June 18 1947 and that I last saw her alive on June 18 - 1947

	DURATION
Immediate cause of death: Cerebral thrombosis	2 weeks
Due to: Arteriosclerosis, Generalized	Many years
Due to:	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: none done Date of op.:

Autopsy results: not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: L. B. Snow M.D.
Address: 914 Sligo Ave. Silver Spring, Md. M. D. or other
Signed 6/18/47

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05129

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4505 Jay St., N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war: W.W. I WWI ✓

3.(a) FULL NAME: BROOKS, Edward Irving

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	C-US	married

6.(b) Name of husband or wife: Marion Brooks

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 27, 1891

8. AGE: Years 55 · Months 11 · Days 3 · If less than one day: hrs. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business: George L. Walker Lumber Co.

FATHER — 12. Name: Brooks, William dec.

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Carter, Elizabeth dec.

MOTHER — 15. Birthplace: Maryland

16. Informant: wife: Mrs. Marion Brooks

Address: 4505 Jay St., N. E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 7-7-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. Ernest Jarvis J.W.H.

Address: 1132 U St., N. W., Wash., D.C.

19. 7-1 (Date rec'd by registrar) 19 47 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 30 June 19 47 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 June 1947 to 30 June 1947 and that I last saw h... im alive on 30 June 1947

	DURATION
Immediate cause of death: Perforated Duodenal Ulcer	2 weeks
Due to: Massive Goitre - infected hemorrhage from duodenal ulcer	3 days
Due to: focal pulmonary collapse, bi-lateral amyloidosis	
Other conditions: Amyloidosis of spleen, liver & heart with marked hepatomegaly (Include pregnancy within 3 months of death)	unknown

Major findings of operations: Date of op.

Autopsy results: As described above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: P. R. ENGLE, Cdr., (MC) USN (M. D. or other)

Address: USNH Bethesda, Md. Date signed: 7-1-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15 9-45-15M

7/16/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a 05130

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:
County Montgomery
City or town Olney, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: The Montgomery County General Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Howard
City or town Clarksville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Cedar Lane Inc.
(If rural, give LOCATION)
2.(a) If veteran, name war √

3.(a) FULL NAME Mrs. Edna Gertrude Brown

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Mr. Britton Brown
6.(c) If alive, give age years

7. Birth data of deceased (mo., day, yr.) 1904

8. AGE:

Years	Months	Days	If less than one day
43	10	20	hrs. min.

9. Birthplace Burnt Mills, Montg. Co. Maryland
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
12. FATHER Name Sam Leizear
13. Birthplace Maryland.
14. MOTHER Maiden name
15. Birthplace
16. Informant Hospital records
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-16-47 (month) (day) (year)
Cemetery or crematory Moreland Memorial Park
Location Baltimore, Md.
18. Funeral director J. C. Higenbottom
Address Ellicott City, Md.
19. 6-13-1947 (Date rec'd by registrar) Gertrude Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1947, at 11:55 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1947, to June 12 1947
and that I last saw her alive on June 12 1947

Immediate cause of death	DURATION
Subarachnoid hemorrhage	2 days
Due to: Essential hypertension	5 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Charles S. Whitaker M.D.
M. D. or other
Address Clarksville, Maryland Date signed 6/13/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 2-45-4

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

05131

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1½ days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 693 Main Avenue, S.W.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: BUCKLEY, Florence Estelle

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 17, 1878

8. AGE:

Years	Months	Days	If less than one day
68	10	24	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER

12. Name: William Cook dec.

13. Birthplace: N.Y.

MOTHER

14. Maiden name: Alice Greenwell dec.

15. Birthplace: Washington, D. C.

16. Informant: daughter: Mrs. Doris Tayman

Address: 693 Main Avenue, S. W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 6-11-47 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: Washington, D.C.

18. Funeral director: Taltavull Funeral Home P.H.T.

Address: 436 7th St., S.W., Wash., D.C.

19. 6-12 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 June 19 47 at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 10 June 19 47 to 11 June 19 47 and that I last saw her alive on 11 June 19 47

Immediate cause of death: Cerebral Hemorrhage.

DURATION: 36 hrs.

Due to: Hypertensive Heart disease.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. T. Fowler Jr. J. T. FOWLER, Jr. Cdr. (MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 6-12-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

6/20/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05132

1310

CP

Reg. Dist. No. 216

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15 9-45-15M

6/20/47

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 78 K St., N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war: WW 1

3.(a) FULL NAME: BURKHOLDER, Floyd Charles

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Laura Burkholder

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 10, 1886

8. AGE:	Years	Months	Days	If less than one day
	60	7	28	..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: unknown

11. Industry or business:

FATHER — 12. Name: Burkholder, Charles dec.

13. Birthplace: Va.

MOTHER — 14. Maiden name: BURKE, Jane dec.

15. Birthplace: Va.

16. Informant: Wife: Mrs. Laura Burkholder

Address: 78 K St., N. W., Wash., D. C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 6-11-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Harry L. Slye, Undertakers

Address: 1009 HSt., N. W., Wash., D.C.

19. 6-9 (Date rec'd by registrar) 19 47 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 June 19 47 at 7:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 May 19 47 to 8 June 19 47 and that I last saw him alive on 8 June 19 47

Immediate cause of death	DURATION
HEMORRHAGE, CEREBELLUM and BRAIN STEM	15 HRS.
Due to ARTERIOSCLEROSIS, GENERAL	9+ Years
Due to	
Other conditions HYPERTENSION, RECENT MYOCARDIAL INFARCTS and ARTERIOLONEPHRO-SCLEROSIS	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: (As above)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. B. Bryan J. B. BRYAN, Lt.(jg)(MC) USNR M. D. or other

Address: USNH Bethesda, Md. Date signed: 6-9-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157a

05133

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since June 14, 1947

Hospital, institution, or street address where death occurred: Suburban Hospital 8600 Old Georgetown Rd. Bethesda Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Monte

City or town Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.R. # I

(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Charlotte A. Calloway

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, ~~married, widowed, or divorced~~
F	W	

6.(b) Name of husband or wife single - child

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 2, 1943

8. AGE: Years	Months	Days	If less than one day
4	4	17	hrs. min.

9. Birthplace Rockville Maryland (Town, county, and state)

10. Usual occupation none - (a child)

11. Industry or business " "

FATHER 12. Name Emory Dove (deceased)

13. Birthplace Virginia

MOTHER 14. Maiden name Elizabeth Simpson

15. Birthplace Kentucky

16. Informant Hospt. Records

Address Bethesda, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/1/47 (month) (day) (year)

Cemetery or crematory Darnestown Cemetery

Location Darnestown, Md.

18. Funeral director Wm Reuben Humphrey

Address Rockville, Md.

19. 6/30 1947 Wm E Jones

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-29 1947, at 8 40 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Terminal Broncho-Pneumonia	2 days.
Due to	
Due to	
Other conditions Hydrocephalus	3 1/2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Hydrocephalus Date of op.

Autopsy results Terminal Broncho-pneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE DeWitt C. DeLawter, Md. M. D. or other

Address Suburban Hosp. Bethesda. Md. Date signed 6/30/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 129

CERTIFICATE OF DEATH

05134

Reg. Dist. No. 2-17

1. PLACE OF DEATH:

County: Montgomery

City or town: Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital Inc.

How long in hospital or institution? 6 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Brinklow

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mr. William Arthur Carr.

3.(b) Social Security Number:

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married.

6.(b) Name of husband or wife: Mrs. Katharyn E. Carr.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 13, 1898

8. AGE: Years: 48 Months: 7 Days: 20 If less than one day: ..... hrs. ..... min.

9. Birthplace: Washington, D. C.

(Town, county, and state)

10. Usual occupation: Builder

11. Industry or business

FATHER

12. Name: Arthur Carr

13. Birthplace: England.

MOTHER

14. Maiden name: Frank Rose Oliver

15. Birthplace: Roanoke, Virginia

16. Informant: Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 5 1947 (month) (day) (year)

Cemetery or crematory: St. Johns Episcopal

Location: Olney, Maryland

18. Funeral director: Warner E. Pumphrey

Address: Silver Spring, Md

19. June 4 1947 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 3 1947 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28 1947, to June 3 1947

and that I last saw him alive on June 3 1947

	DURATION
Immediate cause of death	
Mesentery thrombosis	6 days
Due to	
General peritonitis	3 days.
Due to	
Other conditions: Exploratory Laparotomy	

(Include pregnancy within 3 months of death)

Major findings of operations: See above

Date of op. 5/31/47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: [signature] M. D. or other

Address: Sandy Spring, Md Date signed 6/3/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05135

1700

Reg. Dist. No. 716

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 min

Hospital, Institution, or street address where death occurred: Suburban Hosp.

How long in hospital or institution? 20 min

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Pa County:

City or town: Emporium (If outside city or town limits, write RURAL and give nearest town)

Street No. 300 E. 3rd St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Donald T. Caton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	M

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 24 - 1911

8. AGE: Years	Months	Days	If less than one day
35			hrs. min.

9. Birthplace: Pa (Town, county, and state)

10. Usual occupation: Soldier

11. Industry or business

FATHER — 12. Name: Albert L Caton

13. Birthplace: Pa

MOTHER — 14. Maiden name: Ina M MacDougal

15. Birthplace: Pa

16. Informant: Andrew Field

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 6/4/47 (month) (day) (year)

Cemetery or crematory

Location: Emporium - Pa

18. Funeral director: W. W. Chambers

Address: Mark. Pa

19. 6/2 1947 (Date rec'd by registrar) Mrs E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 2 1947 at 7 00 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Def med Exam case 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Inter. Thoracic Hemorrhage	40 min
Due to: crushed chest	
Due to: (accidental)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 6-2-47

Where did injury occur? Bethesda (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?): highway

Means of injury: auto accident Injured at work?

23. SIGNATURE: Frank J. Bouchard Def Med Exam M. D. or other

Address: Gettysburg Md Date signed: 6-3-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 2-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05136

Reg. Diat. No. 318

1. PLACE OF DEATH:

County: Montgomery

City or town: Goshen md R F D Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? twenty years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: maryland County: Montgomery

City or town: Goshen R F D. Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charly W. Clagett

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	col	marrid

6.(b) Name of husband or wife: mallie Clagett

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): May 31 - 1878

8. AGE: Years: 69 | Months: 0 | Days: 3 | If less than one day: ..... hrs. ..... min.

9. Birthplace: maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farm

FATHER — 12. Name: Charly Clagett

FATHER — 13. Birthplace: Md

MOTHER — 14. Maiden name: Victoria Snowden

MOTHER — 15. Birthplace: Md

16. Informant: Luther Clagett

Address: Gaithersburg md

17. Burial (Burial, cremation, or removal. Which?) Date of... June 7 - 1947 (month) (day) (year)

Cemetery or crematory: Brooke Grove md

Location: Laytonsville md

18. Funeral director: Rol W Barber

Address: Laytonsville Md

19. 6/10 (Date rec'd by registrar) 1947 L. D. Kell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 5th 1947, at 6.30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29 1947, to June 5 1947

and that I last saw him alive on June 4 1947

Immediate cause of death	DURATION
Acute Lobar Pneumonia	8 days
Due to: undetermined	
Due to:	
Other conditions: no	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Vernon H Dyson M.D. M. D. or other

Address: Laytonsville md Date signed: June 7/47

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

47c

Reg. Dist. No. 216 — 05137

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

6/27/47

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 812 20th St., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: Sp.Am.

3.(a) FULL NAME: COCKRELL, Samuel Wootton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 27 July 1880

8. AGE: Years	Months	Days	If less than one day
66	10	11	hrs. min.

9. Birthplace: Va.
(Town, county, and state)
10. Usual occupation: Retired Conductor
11. Industry or business: Railroad

FATHER
12. Name: COCKRELL, Samuel dec.
13. Birthplace: S. C.

MOTHER
14. Maiden name: McCABE, Elizabath dec.
15. Birthplace: Va.

18. Informant: brother: Mr. SelwynCockrell
Address: 812 20th St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 6-12-47 (month) (day) (year)
Cemetery or crematory: GlennWood
Location: Washington, D. C.

18. Funeral director: W. W. CHAMBERS
Address: Georgetown, D. C.

19. 6-10 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 10 19 47 at 10:45AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 May 19 47 to 10 June 19 47 and that I last saw him alive on 10 June 19 47

	DURATION
Immediate cause of death: Adenocarcinomatosis and	Undetermined
Due to: Primary site of carcinoma: bronchogenic	3 weeks
Due to: [illegible]	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Adenocarcinomatosis & bronchopneumonia
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: P. R. Engle
P. R. ENGLE, Cdr.(MC) USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 6-10-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164a

CERTIFICATE OF DEATH

05138

Reg. Dist. No. 714

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~Hospital, institution, or~~ street address where death occurred:

16 Sussex Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 16 Sussex Road

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Eugene A. Collier

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of ~~husband or~~ wife Lauretta S. Collier

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1898

8. AGE: Years	Months	Days	If less than one day
48	8	10	..... hrs. ..... min.

9. Birthplace Nashville, Tenn.

(Town, county, and state)

10. Usual occupation Asst. Director, Statistical

11. Industry or business Research, American Red Cross

FATHER 12. Name Rev. Wm. J. Collier

13. Birthplace Tenn.

MOTHER 14. Maiden name Rhoda M. Anderson

15. Birthplace Tenn.

16. Informant Mrs. Lauretta S. Collier

Address 16 Sussex Rd., Silver Spring, Md

17. Cremation Date thereof June 6, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

~~Cemetery or~~ crematory Cedar Hill

Location Suitland, Md.

18. Funeral director Warner E. Pumphrey

Address Silver Spring, Md.

19. June 5 1947 Joseph M. Schaeffer

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1947 at 5:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1946 19.. to June 4 1947 19..

and that I last saw h... alive on ..... 19..

Immediate cause of death	DURATION
Asphyxia by strangulation (Suicide)	2 min. dead
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 6-4-47

Where did injury occur? Silver Spring (City or town) Mont. (County) Md. (State)

Injured at home, farm, industry, public place (where?) home

Means of injury hanging Injured at work?

23. SIGNATURE Fred J. Brockett M.D.

Deputy Med. Examiner M. D. or other

Address Gaithersburg, Md. Date signed 6-5-47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46e

05139

Reg. Dist. No. 714

1. PLACE OF DEATH: County Montgomery; City or town 122 Philadelphia Ave Tacoma PK (If outside city or town limits, write RURAL and give nearest town); How long in above place of death?; Hospital, Institution, or street address where death occurred:; How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Tacoma PK. (If outside city or town limits, write RURAL and give nearest town)
Street No. 122 Philadelphia Ave. (If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Hayes Baker-Crothers

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married.

6.(b) Name of husband or wife Ruth A. Hudnut 6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) March 2. 1884

8. AGE: Years	Months	Days	If less than one day
63	3	27	..... hrs. ..... min.

9. Birthplace Kansas (Town, county, and state)

10. Usual occupation Pro of History

11. Industry or business American U.

FATHER 12. Name Charles Crothers

13. Birthplace Kansas

MOTHER 14. Maiden name unknown

15. Birthplace Kansas

16. Informant Mrs Ruth A. Hudnut

Address 122 Phila Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 1 1947 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Rt 240-CO. Md.

18. Funeral director W. W. Chambers Co.

Address 1400 - Chapin St. N.W.

19. June 24 1947 (Date rec'd by registrar) Josephine M. Schaaffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1947, at 2:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28 1947, to June 29 1947 and that I last saw h.. alive on June 29 1947

Immediate cause of death	DURATION
metastatic carcinoma of liver	1 yr.
Due to carcinoma of sigmoid	2½ yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE H F Kenyon M. D. or other

Address 7852 16th St N W Washington D.C. Date signed 6/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

05140

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Montgomery Co.

City or town: Glen Echo Heights, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr.

Hospital, Institution, or street address where death occurred:
6908 Waukeska Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Glen Echo Heights, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6908 Waukeska Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Charles A. Curtis

3. (b) Social Security Number: 577-26-1516

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male MALE	White	Married

6.(b) Name of husband or wife: Gladys D. Curtis

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): August 18, 1904

8. AGE: Years	Months	Days	If less than one day
42	10	5	..... hrs. ..... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Mechanic- Bond Bakery

11. Industry or business

FATHER 12. Name: Clarence Curtis

FATHER 13. Birthplace: Virginia

MOTHER 14. Maiden name: Florence Young

MOTHER 15. Birthplace: Virginia

16. Informant: Mrs. Della Miller

Address: 5515 Greenway Dr. Greenacres

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/25/47 (month) (day) (year)

Cemetery or crematory: Potomac Church Cemetery

Location: Potomac, Maryland

18. Funeral director: Wm Reuben Pumphrey

Address: Bethesda, Maryland

19. 6/24 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 23 1947, at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 22 1947, to June 23 1947

and that I last saw h... alive on June 23 1947

Immediate cause of death	DURATION
(a) Coronary occlusion	(a) about 1 hr
Due to:	(b)
Due to:	(c)
Other conditions	(d)

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did Injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: Frank J. Brockhurst M.D. (Attending Phys. or Coroner) M. D. or other

Address: Gaithersburg, Md. Date signed: 6-23-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

05141

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:

County: Montgomery

City or town: Clarksburg md R F D

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Ten Years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Clarksburg md R F D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Eliza Ann Day

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	Widowed

6.(b) Name of husband or wife: Joseph Day

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 1864 - May 3'.

8. AGE: Years	Months	Days	If less than one day
83	1	7	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER — 12. Name: Lloyd Fitts

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Betty Armstrong

MOTHER — 15. Birthplace: Maryland

16. Informant: Marshall Day

Address: Clarksburg Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Jun 14 1947 (month) (day) (year)

Cemetery or crematory: John Wesley

Location: Clarksburg Md

18. Funeral director: Prof W Barber

Address: Laytonsville md

19. Jun 13 1947 (Date rec'd by registrar) Alonda L Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 12 19 47, at 1 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep med Exam 19 ..... to ..... 19 .....

and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Coronary occlusion	Instant
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Broschart M.D. Dep. med. Exam. M. D. or other

Address: Gaithersburg Md Date signed: 6-12-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 7-16

765142

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45

6/7/47

1. PLACE OF DEATH:
County: Montgomery Co.
City or town: Glen Echo Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Glen Echo Heights Rd
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 6310 Wallhonding Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Edna May DuVal

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William M. DuVal
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 23, 1903

8. AGE: * Years	Months	Days	If less than one day
43			..... hrs. ..... min.

9. Birthplace: Va. (Town, county, and state)
10. Usual occupation: C & P Telephone Co.
11. Industry or business:

MOTHER FATHER
12. Name: Oscar Barton
13. Birthplace: Va.
MOTHER
14. Maiden name: Margaret Parsons
15. Birthplace: Va.

16. Informant: Mrs Audrey Scialas
Address: 6310 Wallhonding Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 9th, 1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Suitland Rd., Md.

18. Funeral director: Chas Chance Funeral Home
Address: 5103 Wis. Ave., N.W.

19. 6/7/47 (Date rec'd by registrar) Mrs E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6, 1947, at 2 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1947, to ....., 19..... and that I last saw h... alive on June 1, 1947

Immediate cause of death	DURATION
Carcinoma of uterus	6 mos.
Due to with metastasis to right lung.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Neuratomy 5.6.7.8 thoracic nerves on right. Date of op.: March 1947
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) ..... (County) ..... (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: C P Ryland M. D. or other
Address: 4901 Mass Ave NW Wash 16 D.C. Date signed: 6-6-47

The deceased was a patient in
Garfield Hospital from Jan. until May 23. 1947.
She had a chest X Ray therapy while there
but steadily down hill. X-Ray Chest
revealed a lesion in right chest
probably metastatic in origin. I saw
her for the first time 6 days ago.
yesterday I studied the chest at
Garfield Hospital.
I talked to Dr Brochart at Gaithersburg
this morning telling him the whole
story. He advised me to sign
this certificate.

C P Ryland MD.
6-6-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

C5143

94a

CERTIFICATE OF DEATH

Reg. Diat. No. 218

M

1. PLACE OF DEATH
County Montgomery Co.
City or town Emory Grove
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Emory Grove
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Edward Duvall

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col	Widowed

6.(b) Name of husband or wife Mary Duvall (deceased) 6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) unknown 1895

8. AGE: Years	Months	Days	If less than one day
52			...hrs. ...min.

9. Birthplace Gaithersburg md (Town, county and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Joseph Duvall
13. Birthplace Rockville, md
MOTHER 14. Maiden name Maria ?
15. Birthplace unknown
16. Informant Marion Balsom Address 26 I St. S.E. Wash. DC
17. (Burial, cremation, or removal. Which) Removal to Wash. DC Date (month) (day) (year) July 1, 1947
Cemetery or crematory
Location
18. Funeral director J J Stewart Address 230 H St NE Washington DC
19. July 1 1947 (Date rec'd by registrar) Edward L Cook Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 19 47 at 9:50 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28 19 47 to June 30 19 47
and that I last saw h~~im~~ alive on June 30 19 47
Immediate cause of death coronary thrombosis — OURATION
Due to —
Due to —
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE W Winston Hurley M.D. M. D. or other
Address Gaithersburg Date signed June 30/47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

05144

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 years

Hospital, institution, or street address where death occurred: 4818 Del Ray Avenue

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4818 Del Ray Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: CATHERINE C. ECKENRODE

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Mack

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May 12, 1880

8. AGE: Years	Months	Days	If less than one day
67	--	22	____ hrs. ____ min.

9. Birthplace: Montgomery Co., Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER

12. Name: Edward Cooley

13. Birthplace: Montgomery Co., Md.

MOTHER

14. Maiden name: Louise Austin

15. Birthplace: Montgomery Co., Md.

16. Informant: Mr. Mack Eckenrode

Address: 4818 Del Ray Ave., Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6/7/47 (month) (day) (year)

Cemetery or crematory: Mt. Olivet

Location: Fredrick, Maryland

18. Funeral director: Wm Reuben Humphreys

Address: 7557 Wisconsin Ave, Bethesda, Md.

19. 6/4 19 47 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 3, 1947 at 3:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAY 15 1947, to JUNE 3 1947 and that I last saw HER alive on JUNE 3 1947

Immediate cause of death	DURATION
CARDIAC DECOMPENSATION WITH PULMONARY CONGESTION	1 YEAR
Due to (2) HYPERTENSIVE HEART DISEASE WITH MARKED CARDIAC ENLARGE.	5 YEARS -?
Due to (3) ARTERIOSCLEROTIC HEART DISEASE WITH CORONARY SCLEROSIS	10 YEARS
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. —

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert G. Angle M.D. M. D. or other

Address: Bethesda, Md. Date signed: June 4, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

05146

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. 424 Taylor St.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME JAMES ALLEN EVANS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Sarah Roselle Evans

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 18, 1863

8. AGE: Years	Months	Days	If less than one day
83	7	4	..... hrs. ..... min.

9. Birthplace Coles County, Ill.

(Town, county, and state)

10. Usual occupation Dept. Agriculture

11. Industry or business U.S. Govt.

FATHER 12. Name Seth Evans

13. Birthplace Kentucky

MOTHER 14. Maiden name Sarah Norton Tyffe

15. Birthplace Tenn.

16. Informant J. Wesley Buchanan

Address 9909 Kingston Rd.

17. Burial Date thereof June 25 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Ft. Lincoln Cem

Location

18. Funeral director The S.N. Hines Co

Address 2901 - 14 at NW

19. 6/23 1947 Wm E Jobes

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22. 1947 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 22 1947, to June 22 1947

and that I last saw h[illegible] alive on June 22 1947

Immediate cause of death	DURATION
Hemiplegia Coronary Thrombosis	Sudden
Due to Coronary Sclerosis	Many yrs.
Due to Senile arteriosclerosis	
Other conditions Cerebral hemorrhage. Left hemiplegia.	13 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. Marvin Logan M.D.

M. D. or other

Address 1150 Conn. Ave. Washington, D.C. Date signed 6-23-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Deceased subject to anginal attacks for many years. Cerebral vascular accident (cerebral hemorrhage) occurred 6.9.47. Recovery of function almost complete on 6.23.47. Condition good. At 3 a.m. last death occurred suddenly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 05147

Reg. Dist. No. 211

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Damascus

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? All her life

Hospital, institution, or street address where death occurred:

At her home, Damascus, Md.

How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Damascus

(If outside city or town limits, write RURAL and give nearest town)

Street No. --

(If rural, give LOCATION)

2.(a) If veteran, name war: --

3. (a) FULL NAME: Alcinda Fairchild

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Walter R. Fairchild, deceased

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): January 11, 1875

8. AGE: Years	Months	Days	If less than one day
72	5	15	..... hrs. ..... min.

9. Birthplace: Montgomery County, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER
12. Name: George E. Ward
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Crown
15. Birthplace: Maryland

16. Informant: Nellie M. Fairchild
Address: Damascus, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 28, 1947 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Damascus, Maryland

18. Funeral director: Roy W. Barber

Address: Leytonsville, Md.

19. June 28 1947 (Date rec'd by registrar) Della N. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26 1947, at 8:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26 1947, to June 26 1947

and that I last saw her alive on June 25 1947

Immediate cause of death	DURATION
Congestive heart failure	1 mo.
Due to Arteriosclerotic heart disease	10 yrs
Due to	
Other conditions Generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Ralston H. Adams, M.D.
M. D. or other

Address: Damascus, Md. Date signed 6-27-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

C5148

Reg. Dist. No. 123

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 yrs.

Hospital, institution, or street address where death occurred: Washington Sanitarium and Hospital

How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7755 Georgetown Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: James D. Federline

3.(b) Social Security Number: none

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Mrs. Mary Federline

6.(c) If alive, give age: living years

7. Birth date of deceased (mo., day, yr.): January 21, 1901

8. AGE: Years	Months	Days	If less than one day
44	5	8	— hrs. — min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Grocer

11. Industry or business: U.G.S. Store - owner

FATHER
12. Name: Charles F. Federline
13. Birthplace: Leesburg, Virginia

MOTHER
14. Maiden name: Estelle P. Riley
15. Birthplace: Washington, D.C.

16. Informant: Hazel E. Muller

Address: 334 Garland Ave, Takoma Pk. Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: June 29 1947 (month) (day) (year)

Cemetery or crematory: Bethesda Md.

Location: Bethesda - Md.

18. Funeral director: W. B. Thompson Funeral Service

Address: Bethesda 14 Md.

19. June 30 1947 (Date rec'd by registrar) J. Wilson Booth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6/29 1947, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1946 to June 29 1947 and that I last saw h.. alive on June 29 1947

Immediate cause of death	DURATION
Uremia	2 week
Coronary Thrombosis	3 days
Due to: Bilateral Polycystic Kidney disease (Congenital)	
Due to:	
Other conditions: Hypertension	6 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Bruce T. Benjamin M.D. M. D. or other

Address: Bethesda 14 Md. Date signed: 6/29/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95C

CERTIFICATE OF DEATH

05149

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5-42

Hospital, institution, or street address where death occurred:

8722 Colesville Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Monty

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8722 Colesville Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William P. Ferguson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Mayme V. Ferguson

6.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.): Nov 15 1873

8. AGE:

Years	Months	Days	If less than one day
73	7	1	...hrs. ...min.

9. Birthplace: Washington DC (Town, county, and state)

10. Usual occupation: Retired gov. employee

11. Industry or business

FATHER

12. Name: John Ferguson

13. Birthplace: Wash. DC

MOTHER

14. Maiden name: Nellie Scott

15. Birthplace: Wash. DC

16. Informant: Mrs Mayme V. Ferguson wife

Address: 8722 Colesville Rd Silver Spring Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof 6-19-47 (month) (day) (year)

Cemetery or crematory: Glenwood Cem

Location: Wash. DC

18. Funeral director: Nelson K Hunter

Address: 5732 Georgia Ave NW

19. June 16 1947 (Date rec'd by registrar) Josephine Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 16 1947, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1946 1947, to 1947

and that I last saw h... alive on June 16 1947

	DURATION
Immediate cause of death: Acute Cardiac dilatation	1/2 hr.
Due to: Chronic heart disease	1 yr.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Boschat M.D. M. D. or other

Address: Gaithersburg Md Date signed 6-16-47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

132 . 05150

CERTIFICATE OF DEATH

Reg. Diat. No. 714

1. PLACE OF DEATH:

County Montgomery

City or town Sil. Spring.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

10725 Ga. Ave Sil Spring

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Victor A Frank

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Josephine Sieler

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 6th 1873

8. AGE:

Years	Months	Days	If less than one day
74			..... hrs. ..... min.

9. Birthplace Washington DC

(Town, county, and state)

10. Usual occupation Florist

11. Industry or business

FATHER 12. Name Joseph Frank

13. Birthplace

MOTHER 14. Maiden name Josephine Sieler

15. Birthplace

16. Informant Victor Frank

Address 10725 - Ga. Ave. Sil Spring

17. Removal + Burial (Burial, cremation, or removal. Which?) Date thereof June 24, 1947 (month) (day) (year)

Cemetery or crematory Washington DC

Location Mt Olivet

18. Funeral director Thomas B. Hanlon

Address 641 H St N E

19. 6/21 (Date rec'd by registrar) 19 47 Josephine M Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 19 47, at 10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 19 47 to June 24 19 47

and that I last saw him alive on June 21 19 47

Immediate cause of death	DURATION
Acute Cardiac - failure	
Due to Nephritis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos D Harrington M. D. or other

Address 1346 Mass Ave NE Date signed 6/21/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

at 3570

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a CD

05151

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 127 C Street, Northeast
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME: FRIEND, William Lawrence

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 11 April 1891

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
56	1	21		

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: Librarian

11. Industry or business: Library of Congress

FATHER — 12. Name: William Friend, dec.

13. Birthplace: West Virginia

MOTHER — 14. Maiden name: Bessie Griffin

15. Birthplace: Ireland, dec.

16. Informant: Sister: Mrs. Laura M. Flynn

Address: 5751 Woodstock St., Phila., Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-6-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W.W. CHAMBERS & Son

Address: 5801 Cleveland Ave., Riverdale, Md.

19. 20 June 1947 (Date rec'd by registrar) Registrar: Mary Charlotte Smith

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 June 1947, at 10:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-26- 1947, to 6-1- 1947

and that I last saw him alive on 6-1- 1947

	DURATION
Immediate cause of death: CORONARY THROMBOSIS	12 hours
Due to: CORONARY ARTERY DISEASE, ARTERIOSCLEROTIC	1 year
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: NOT GRANTED BY FAMILY

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J.B.Bryan
J.B.BRYAN, LTJG MC USNR
M. D. or other

Address: USNH, Bethesda, Md. Date signed: 6-2-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

6/10/47

05152

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Montgomery
City or town: Cedar Grove
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Cedar Grove
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Robert Lee Gray.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Anna Gray
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 25, 1870

8. AGE: Years	Months	Days	If less than one day
77			hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden name
15. Birthplace

16. Informant: Anna Gray
Address: Cedar Grove, Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 13, 1947 (month) (day) (year)
Cemetery or crematory: Rocky Hill
Location: Clarksburg, Md.

16. Funeral director: R. L. Snouffer
Address: Rockville, Md.

19. June 13 1947 (Date rec'd by registrar) Alveda H. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1947, at 8:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 15 1945, to June 9 1947
and that I last saw him alive on 1947

Immediate cause of death	DURATION
Arteriosclerotic cardio-vascular disease	15 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James P. Kerr M.D.
M. D. or other
Address Damascus, Md. Date signed 6/11/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05153

Reg. Dist. No. 5-14

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ?

Hospital, Institution, or street address where death occurred:

B & O R.R. station

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Hyattsville, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4008 Ingraham St.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME: Gregory, Jesse Elwood

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	~~married~~ Divorced

6.(b) Name of husband or wife: Vreeland Cox

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 2-27-1897

8. AGE: Years	Months	Days	If less than one day
50	3	25	..... hrs. ..... min.

9. Birthplace: Frederick County, Va.

(Town, county, and state)

10. Usual occupation: Fireman

11. Industry or business: D.C. Fire Dept.

FATHER — 12. Name: John J. Gregory

13. Birthplace: Gregorytown, New York

MOTHER — 14. Maiden name: Mary Catherine Light

15. Birthplace: Warren County, Va.

16. Informant: John Lawrence Gregory

Address: Stephens City, Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 19, 1947 (month) (day) (year)

Cemetery or crematory: City Cemetery

Location: Stephens City, Virginia

18. Funeral director: Martin W. Tyson Co.

Address: 1300 - N 22 N.W., Wash. D.C.

19. 6/17/47 (Date rec'd by registrar) Josephine K. Schaefer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 16, 1947, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 2nd Exam 19.. to ..... 19.. and that I last saw h.. alive on ..... 19..

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Broccard M.D. Dep. Med. Exam. M. D. or other

Address: Gaithersburg Md. Date signed: 6-16-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

05154

CERTIFICATE OF DEATH

Reg. Dist. No. 218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:

County: Montgomery

City or town: Laytonsville MD. Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 64 Yers

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rural Laytonsville MD.
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION) No

2.(a) If veteran, name war

3. (a) FULL NAME: Jeffrey Magruder Griffith

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lillian Neel Griffith

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 14. 1882

8. AGE: Years	Months	Days	If less than one day
64	7	1	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business: Farm

FATHER
12. Name: William R. Griffith
13. Birthplace: Laytonsville MD.

MOTHER
14. Maiden name: Isabella Griffith
15. Birthplace: Maryland

16. Informant: Lillian Neel Griffith
Address: Gaithersburg MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 17 1947 (month) (day) (year)
Cemetery or crematory: Neelsville MD.
Location: Montgomery Co. MD.

18. Funeral director: Roy W. Barber
Address: Laytonsville MD

19. 6/17 1947 (Date rec'd by registrar) L. D. Bell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 15 1947, at 6:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 21, 1941 to June 15, 1947 and that I last saw h. l. M. alive on June 14, 1947

Immediate cause of death	DURATION
Coronary occlusion	10 days
Due to: Arteriosclerotic cardiovascular disease	10 years
Due to:	
Other conditions: Bronchial asthma	15 years

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James P. Kerr M.D. M. D. or other

Address: Damascus, Md. Date signed: 6/16/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

05155

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Chevy Chase Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4602 Ft. Pleasant Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: Work

3.(a) FULL NAME: Amos J. Grimes

3.(b) Social Security Number: 218-20-0646

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Ethel May Grimes
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 9 1879

8. AGE: Years: 67 Months: Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Prince George Md (Town, county, and state)
10. Usual occupation: Retired Barber
11. Industry or business: Retired
FATHER 12. Name: William Grimes
13. Birthplace: Md
MOTHER 14. Maiden name: Elizabeth Devaughn
15. Birthplace: Talbot Co. Md.
16. Informant: Ethel May Grimes
Address: 4602 Ft. Pleasant Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 4 (month) (day) 47 (year)
Cemetery or crematory: Congressional
Location: Montgomery Co. Md.
18. Funeral director: A. L. Chambers Co.
Address: 2711 M St. N.W.
19. 6/2 1947 Wm E Jobes (Registrar)
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 1, 1947, at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1947 to June 1, 1947 and that I last saw him alive on June 1, 1947

Immediate cause of death	DURATION
Cirrhosis of Liver	
Due to	
Due to	
Other conditions: Diabetes mel.	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: B. F. Farmer M. D. or other
Address: 7202 Conn. Ave. Date signed: 6-1-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

05156

Reg. Diat. No. 212

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County Montgomery
City or town Barnesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 54 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Monty
City or town Barnesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Cora Hallman

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	married

6.(b) Name of husband or wife Arthur Hallman
6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) June 2 - 1893

8. AGE: Years	Months	Days	If less than one day
54	0	0	...hrs. ...min.

9. Birthplace Barnesville Monty Co. Md (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Thomas Ousley
13. Birthplace Maryland
MOTHER 14. Maiden name Annie Hallman
15. Birthplace Maryland
16. Informant Arthur Hallman
Address Barnesville, md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof June 5 - 47 (month) (day) (year)
Cemetery or crematory Bells Chapel
Location Hickerson, Md.
18. Funeral director William B. Hilton
Address Barnesville, md.
19. June 3, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 - 1947, at 2:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 31 - 1947, to June 3 - 1947
and that I last saw h alive on June 2 - 1947
Immediate cause of death

	DURATION
Cerebral hemorrhage	3 days.
Due to Arterio sclerosis & hypertension	3 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Byron S. White, M.D. M. D. or other
Address Poolesville, Md. Date signed 6/3/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

48a X

05157

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery County

City or town: Takoma Park, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Washington San. & Hospital, Takoma Park, Md.

How long in hospital or institution? 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9300 Worth Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Hedges, Mrs. Ethel Margaret

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	White	Married

6.(b) Name of husband or wife: Mr. Floyd E. Hedges

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 24, 1890

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
56	8	20		

9. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Mr. William Pond
13. Birthplace: Conn.

MOTHER
14. Maiden name: Mrs. Hattie Pond
15. Birthplace: Washington, D.C.

16. Informant: From patient's admission Record - which was received from husband.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 19, 1947 (month) (day) (year)
Cemetery or crematory: Rock Creek Cem.
Location: Wash., D.C.

18. Funeral director: Neal Funeral Home
Address: 4812 Ga Ave N.W.

19. June 14 1947 (Date rec'd by registrar) J. W. Dudley Jr. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 13 1947 at 11:39 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1947, to June 13 1947 and that I last saw h.. alive on June 13 1947

	DURATION
Immediate cause of death: (a) Generalized Carcinomatosis	1 yr +
Due to: (b) Carcinoma of Cervix uteri	4 yrs +
Due to: (c)	
Other conditions: Jaundice	

(Include pregnancy within 3 months of death)

Major findings of operation: No Surgery. X-Ray therapy 2 years ago. Paralled Hood. Date of op.

Autopsy results: Work

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE. If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Lead M. Calvert M.D. M. D. or other

Address: Silver Spring Md. Date signed: 6-14-47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

05145

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery

City or town Rural - Silver Spring (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred: Home

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rural - Silver Spring (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME HEDGES, Leslie Elsworth

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Harriet G.

6.(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) April 15, 1874

8. AGE: Years 73 | Months 1 | Days | If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business Farm

FATHER 12. Name Joseph Hedges

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Sophia Refauver

MOTHER 15. Birthplace Maryland

16. Informant Mrs Harriet G. Hedges

Address Silver Spring Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-12-47 (month) (day) (year)

Cemetery or crematory Lutheran

Location Middletown Md.

18. Funeral director C. H. Fuller & Bro

Address Brunswick Md

19. 6-11-47 19 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10/47 19 at 7:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 23/47 19 to June 10/47 19 and that I last saw h. in alive on May 27 47 19

Immediate cause of death	DURATION
Congestive Heart Failure	1 yrs
Due to Arteriosclerosis generalized	15 yrs
Senes	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Sam Allen M.D. M. D. or other

Address Kensington Md Date signed June 10/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

13 Election Dist
Mrs Josephine Hamilton

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05158

46g CP

Reg. Diat. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, IN UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M 7/47

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 1 day

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 months, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3473 Holemad Place, N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war: 1st WW

3. (a) FULL NAME: HENRY, Brady Allen,

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 18, 1880

8. AGE: Years	Months	Days	If less than one day
67	0	17	hrs. min.

9. Birthplace: Miss. (Town, county, and state)

10. Usual occupation: unknown

11. Industry or business:

FATHER — 12. Name: William A. Henry dec.

FATHER — 13. Birthplace: Miss.

MOTHER — 14. Maiden name: Loula Anderson dec.

MOTHER — 15. Birthplace: Miss

16. Informant: sister: Mrs. R. S. Cox

Address: 3473 Holemad Place, N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 6-9-47 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS E.J.

Address: 1400 Chapin St., N.W., Wash., D.C.

19. 6-6 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 June 1947, at 6:15P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 4 1947, to 5 June 1947 and that I last saw h... im... alive on 5 June 1947

	DURATION
Immediate cause of death: Carcinoma of Pancreas, metastatic to liver, stomach	1 yr.
Due to: heart & lungs	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Cx noted above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R. N. Grant R. N. GRANT, Cdr. (MC) USN M. D. or other

Address: USNH Bethesda, Md. Date signed: 5-6-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05159

46 e

Reg. Diat. No. 216

1. PLACE OF DEATH:—
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 m.
Hospital, institution, or street address where death occurred:
4815 Rugby ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4815 Rugby Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war None.

3.(a) FULL NAME George Wesley Hess. Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	W.	Married.

6.(b) Name of husband or wife Mrs Helen Dorothy Callahan
6.(c) If alive, give age 44 years
7. Birth date of deceased (mo., day, yr.) 14 June 1864.

8. AGE: Years	Months	Days	If less than one day
82	11	24	hrs. min.

9. Birthplace George Town D.C.
(Town, county, and state)
10. Usual occupation Horticulturest.
11. Industry or business Director of U.S Botanical Gardens

FATHER
12. Name George W. Hess.
13. Birthplace George town D.C

MOTHER
14. Maiden name Mary Robinson.
15. Birthplace Va.

16. Informant Wife.
Address 4815 Rugby ave. Beth. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 9 1947 (month) (day) (year)
Cemetery or crematory Glenwood Cemetery
Location Washington, D.C.

18. Funeral director Wm Reuben Dunphrey
Address Bethesda, Maryland

19. 6/7 1947 Wm E Jobes Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 June 1947, at 4:50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 18 April 1947, to 6 June 1947 and that I last saw h.i.m. alive on 4 June 1947

Immediate cause of death	DURATION
[redacted] Pneumonia Terminal	2 days
Due to Carcinoma of Sigmoid	
Due to	
Other conditions Diabetes Mellitus Arteriosclerosis generalized	

(Include pregnancy within 3 months of death)

Major findings of operations Inoperable Carcinoma of Sigmoid Date of op. 29 April 47
Autopsy results None.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John G Ball M.D.
M. D. or other
Address 7926 Bradley Blvd Bethesda Md. Date signed 6 June 47

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

50 A

05160

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Rural Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Rural Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.F.D. #3
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Irene Margaret Johnson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M.

6.(b) Name of husband or wife: Otis Hayward Johnson

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 28, 1903

8. AGE: Years: 43 | Months: 11 | Days: 19 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Wash. D.C.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: Phillip Heffron
13. Birthplace: Wash. D.C.

MOTHER
14. Maiden name: Nettie E. Robey
15. Birthplace: Md.

16. Informant: Otis Hayward Johnson
Address: Rural R.F.D. #3 Bethesda, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 6/9/47 (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director: The J.W. Hines Co.

Address: 2901 14th St. N.W.

19. 6/9 19 47 (Date rec'd by registrar) Mrs E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 9 19 47, at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14 19 47, to June 9 19 47 and that I last saw h.. alive on June 9 19 47

Immediate cause of death	DURATION
Acute Congestive Myocarditis	
Due to Metastatic Carcinoma of Liver	
Due to Scirrhous Carcinoma of Breast (R.)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Scirrhous Carcinoma of rt. Breast Date of op. Jan 1947

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Harry S. Douglas M.D
M. D. or other

Address: 1623 Columbia Rd West D.C. Date signed 6/9/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

92 b CB 05161 Reg. Dist. No. 314

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~XXXXXXXXX~~ or street address where death occurred:
617 Lycoming Ave.,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Missouri County: St. Louis

City or town: St. Louis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4889 Margaretta Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Mrs. MARY FRANCES KALLMEIER

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

B.(b) Name of husband or wife: Henry Louis 8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 16th. 1867

8. AGE: Years	Months	Days	If less than one day
80	2	3	..... hrs. ..... min.

9. Birthplace: St. Louis, Mo.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: ? Wachter
13. Birthplace: Germany

MOTHER
14. Maiden name: ? Harnish
15. Birthplace: Germany

18. Informant: Mrs. Wm. H. Biebusch
Address: 617 Lycoming Ave. Silver Spg.

17. Trans'N & Burial Date thereof: 6/20/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: xxxx Memorial Park

Location: St. Louis Co., Mo.

18. Funeral director: Wamel E Pumphrey -

Address: Silver Spring, Md.

19. 6-20- 19..47 Josephine Mc Shaffe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 19 June 1947, at 12 40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 June 1947, to 19 June 1947 and that I last saw her alive on 18 June 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage, Right.	20 hours.
Due to: Arteriosclerotic Vascular Disease	Few years.
Due to:	
Other conditions: Mitral regurgitation	?
Left indirect Inguinal Hernia -	?

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: G B Cullen M.D.
M. D. or other

Address: 112 Willow Ave. Takoma Park, Md. Date signed: 19 June 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

106 C

05162

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Suburban Hospital
City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Dead on arrival
Hospital, Institution, or street address where death occurred:
8600 Old Georgetown Rd. Bethesda Md.
How long in hospital or institution? Dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: MONTGOMERY
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Meadowood
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Elizabeth Anne Kay

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, ~~married, widowed, or divorced~~
F	W	

6.(b) Name of husband or wife: child
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 13, 1941

8. AGE: Years	Months	Days	If less than one day
5	7	9	..... hrs. ..... min.

9. Birthplace: Sandy Springs Md.
(Town, county, and state)
10. Usual occupation: child
11. Industry or business

MOTHER FATHER
12. Name: Joseph Kay
13. Birthplace: Washington D.C.
MOTHER
14. Maiden name: Doris Gregory
15. Birthplace: Washington D.C.

16. Informant: Mrs Joseph Kay
Address: Meadowood - Silver Spring - Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 24 1947 (month) (day) (year)
Cemetery or ~~crematory~~: Colesville Methodist Church
Location: Colesville. Monty Co. Md.
18. Funeral director: Wayne E. Pumphrey
Address: Silver Spring - Md

19. 6/25/1947 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION Dead on arrival

20. DATE OF DEATH: 6-22 1947 at about 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep med exam case 19.. to ..19..
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute epiglottitis and laryngo-tracheo bronchitis	24 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Bonhart M.D. Dep. med. Exam M. D. or other
Address: Gaithersburg Md. Date signed 6-22-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

From Sec. Reg.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05163

55c

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months 16 days

Hospital, Institution, or street address where death occurred:

US NAVAL HOSPITAL, Bethesda, Md.

How long in hospital or institution? 4 months, 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Mt. Victoria

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: WW 1

3.(a) FULL NAME: KELLAM, William Thomas

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	~~W~~ Col.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth data of deceased (mo., day, yr.): December 19, 1891

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
55	5	22		

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: unknown

11. Industry or business:

FATHER

12. Name: Mrs. William T. Kellam dec

13. Birthplace: Va.

MOTHER

14. Maiden name: Rose Bailey dec.

15. Birthplace: Va.

16. Informant: sister: Mrs. Cordie Strand

Address: Onley, Va.

17. removal (Burial, cremation, or removal. Which?) Date thereof 6-16-47 (month) (day) (year)

Cemetery or crematory:

Location: Tasley, Virginia

18. Funeral director: W. ERNEST JARVIS

Address: 1432 U St., N. W., Wash., D.C.

19. 6-13 19 47 Mary Charlotte Smith (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH: 11 June 19 47 at 11:35 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 January 19 47, to 11 June 19 47

and that I last saw h alive on 19

Immediate cause of death	DURATION
Pulmonary edema	
Due to Malignant Carcinoid Ovary tumor c lymph node & liver metastases	
Due to	
Other conditions Generalized arterio sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. D. WYCOFF, Lt. (jg) (MC) USNR

M. D. or other

Address: USNH Bethesda, Md. Date signed: 6-12-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-5


RECEIVED
9 1947
BUREAU F.C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05164

164a

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~Hospital, institution, or~~ street address where death occurred:

711 Sligo Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 711 Sligo Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war World War II

3.(a) FULL NAME Ralph E. Killerlain

3.(b) Social Security Number 579-10-3736

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 11, 1925

8. AGE:

Years	Months	Days	If less than one day
21	10	23	..... hrs. ..... min.

9. Birthplace Waterloo, Iowa

(Town, county, and state)

10. Usual occupation Food Dispenser for

11. Industry or business Peoples Drug Store # 20

FATHER 12. Name Myron C. Killerlain

13. Birthplace Fayette, Iowa

MOTHER 14. Maiden name Hilda Matilda Mumm

15. Birthplace Davenport, Iowa

16. Informant Mrs. Hilda M. Killerlain

Address 711 Sligo Ave., Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 6, 1947 (month) (day) (year)

Cemetery ~~or crematory~~ Arlington National

Location Fort Myer, Va.

18. Funeral director Warner E. Pumphrey

Address Silver Spring, Md.

19. June 5 19 47 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 19 47, at 1 0'clock A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep. Med. Exam. Case 19 ..... to ..... 19 .....

and that I last saw h..... alive on ..... 19 .....

	DURATION
Immediate cause of death	
Asphyxia by strangulation	Prob. dead in time
Due to Suicide	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 6-6-47

Where did injury occur? Silver Spring (City or town) Montg. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury hanging Injured at work?

23. SIGNATURE Frank J. Broschart M.D. Dep. Med. Exam. M. D. or other

Address Gaithersburg Md. Date signed 6-6-47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05165

176 CB

CERTIFICATE OF DEATH

Reg. Dist. No. 716

1. PLACE OF DEATH:
County MONTGOMERY.
City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
DEAD ON ARRIVAL
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D. C. County
City or town Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 706 - 11th STREET N.W. Wash. D.C.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME KULLE, August C.

3.(b) Social Security Number 579-12-5163

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	White	Divorced

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1871

8. AGE: Years	Months	Days	If less than one day
76	5	1	hrs. min.

9. Birthplace Annapolis, Maryland (Town, county, and state)
10. Usual occupation Inspector, Glen Echo, Md.
11. Industry or business

FATHER
12. Name Louis Kulle
13. Birthplace Hafe Cope Germany

MOTHER
14. Maiden name Frederica Becker
15. Birthplace Hafe Cope Germany

16. Informant Mr. George F. Kulle
Address 1748 Q St. N. W. Washi. D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/27/47 (month) (day) (year)
Cemetery or crematory Congressional Cemetery
Location Washington, D. C.

18. Funeral director Wm Reuben Humphreys
Address Bethesda, Maryland

19. 6/25 1947 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1947, at 5:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Compound fracture of skull	few min.
Contusion Chest	
Due to Intra Thoracic Hemorrhage	
Due to (Accident)	
Other conditions Fracture of rt & left Thigh, Fracture left & left leg	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accidental Date of 6-23-47
Where did injury occur? Glen (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Glen Echo Park
Means of injury Struck by Roller Coaster Injured at work? Yes

23. SIGNATURE Frank J. Brosnan M. D.
Dep. Med. Exam. M. D. or other
Address Gaithersburg Md. Date signed 6-23-47

VS-A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

05166

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46e

CERTIFICATE OF DEATH

Reg. Dist. No. 217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County: Montgomery

City or town: Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: The Montgomery County General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R# 4

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Benjamin Marriott

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Widowed.

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1877

8. AGE: Years: ? 70+ Months: Days: If less than one day: hrs. min.

8. Birthplace: Montgomery County, Md. (Town, county, and state)

10. Usual occupation: Laborer.

11. Industry or business

FATHER 12. Name: Thomas Marriott

13. Birthplace: Md.

MOTHER 14. Maiden name: Caroline Baker

15. Birthplace: Md.

16. Informant: Hospital records.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 9 1947 (month) (day) (year)

Cemetery or crematory: Church Cemetery

Location: Sandy Spring, Md

18. Funeral director: R. B. Anderson

Address: Rockville, Md

19. 6-9 1947 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6 1947, at 2:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24 1947, to June 6 1947

and that I last saw him alive on June 6 1947

	DURATION
Immediate cause of death: Carcinoma of Descending Colon	? 2-3 months
Due to:	
Due to:	
Other conditions: Arteriosclerosis Generalized	Many ?

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of descending colon Date of op. 5-26-47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. W. Bird per R.R.W. M. D. or other

Address: Montgomery Co. Gen. Hosp. Date signed 6-6-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

05167

CERTIFICATE OF DEATH

Reg. Dist. No. 21 F

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~How long~~ street address where death occurred:
9412 Mintwood Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9412 Mintwood Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war no

3.(a) FULL NAME JOHN P. McGLAUGHLIN

3.(b) Social Security Number 080-01-5921

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of ~~husband~~ wife Mabel Cundry

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 4th. 1881

8. AGE: Years	Months	Days	If less than one day
65	7	27	..... hrs. ..... min.

9. Birthplace St. Louis, Mo.
(Town, county, and state)

10. Usual occupation Engineer (Retired)

11. Industry or business Standard Brands, Inc.

FATHER
12. Name Geo. Wm. McGlaughlin
13. Birthplace Ky.

MOTHER
14. Maiden name Eleanor Johnson
15. Birthplace Iowa

16. Informant Mrs. Mabel C. McGlaughlin
Address 9412 Mintwood Rd. Silver Spg.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 3rd. '47 (month) (day) (year)

Cemetery or crematory Rock Creek Cemetery

Location Washington, D. C.

18. Funeral director Warner E. Pumphrey

Address Silver Spring, Md.

19. June 3 19-47 (Date rec'd by registrar) Josephine M. Schaeffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 19 47 at 11:40 A.P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dep Med Exam 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	½ hr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Frank J. Bouchat M.D.
Dep Med Exam. M. D. or other

Address Silver Spring, Md. Date signed 6-2-47

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164c

05168

CERTIFICATE OF DEATH

Reg. Dist. No. 292

1. PLACE OF DEATH:

County: Montgomery

City or town: Damestown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Damestown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Charles C. Miles

3. (b) Social Security Number: 218-09-5147

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 26 1878

8. AGE:

Years	Months	Days	If less than one day
68	10	15	..... hrs. ..... min.

9. Birthplace: Clarksburg Maryland

(Town, county, and state)

10. Usual occupation: laborer

11. Industry or business

FATHER

12. Name: Lemuel Miles

13. Birthplace: Md

MOTHER

14. Maiden name: Martha Grimes

15. Birthplace: Md

16. Informant: Mrs Wm T. Miles

Address: Gaithersburg R-3. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/13/47 (month) (day) (year)

Cemetery or crematory: Methodist

Location: Hyattstown, Md.

18. Funeral director: William B. Hilton

Address: Barnesville, Md.

19. June 12 1947 (Date rec'd by registrar) Mrs. C. C. Hilton By Mrs. W.B.H. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11 1947, at 5:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 9 1947, to June 11 1947, and that I last saw h alive on June 11 1947

Immediate cause of death	DURATION
Hemorrhage	
Due to Shot gun wound in left chest	
Due to (accident)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 6-11-47

Where did injury occur? Damestown (City or town) Montg (County) Md (State)

Injured at home, farm, industry, public place (where?) home

Means of injury: Shot gun Injured at work? no

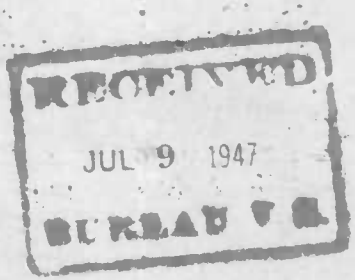
23. SIGNATURE: Frank J. Brouhard M.D. (M. D. or other)

Address: Gaithersburg Md Date signed 6-11-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.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JUL 9 1947
BUREAU F B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

137a

CERTIFICATE OF DEATH

05169

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Schottroff
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Jacob Mc Millen

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 3, 1873

8. AGE: Years: 73 | Months: 10 | Days: 9 | If less than one day: hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Sawmill worker

11. Industry or business:

FATHER
12. Name: William W. Mc Millen
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Priscilla Riley
15. Birthplace: Va.

16. Informant: Luther F. Mc Millen (Brother)
Address: 6817 Georgia Ave. NW. Wash. D.C.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: 6/14/47 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Maryland

18. Funeral director: Wm. Reuben Rumphrey
Address: Bethesda, Maryland

18. 6/13 19 47 Wm E Jones Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 12, 1947, at 8 15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 1947, to June 12 1947 and that I last saw him alive on June 12 1947

Immediate cause of death	DURATION
Bilateral Pyonephrosis	3 wk?
Due to: Chronic Prostatic Hypertrophy	years?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Pyonephrosis, Bilat. Middle Lobe Prostate
PHYSICIAN: Please underline the cause to which death should be charged statistically. En Log 6/16/47

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: DeWitt E. DeSautter M.D.
M. D. or other
Address: Suburban Hosp. Bethesda Md. Date signed: 6/13/47

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

166

05170

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 8 hours, 35 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Clarksburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME George Walter Moore

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 12, 1923

8. AGE: Years 24 | Months | Days 3 | If less than one day ..... hrs. ..... min.

9. Birthplace Clarksburg, Maryland
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Alfred H. Moore
13. Birthplace New Market, Maryland

MOTHER
14. Maiden name Corabell Chaney
15. Birthplace New Market, Maryland

18. Informant Corabell Moore
Address Clarksburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jun 17 1947 (month) (day) (year)
Cemetery or crematory John Wesley
Location Clarksburg Md

18. Funeral director Roy W. Barber
Address Laytonsville Md

19. 6/16 1947 Wm E Jones Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1947, at 5:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Intracranial Hemorrhage	10 hrs
Due to Laceration of Brain	10 hrs
Due to Fracture of Skull	10 hrs
Other conditions Bullet Wound	10 hrs

(Include pregnancy within 3 months of death)

Major findings of operations Fracture of Skull. Hemorrhage of Lacerated Brain Date of op. 6/14/47

Autopsy results above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Homicide Date of 6/14/47
Where did injury occur? Don't know (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Don't know
Means of injury — Injured at work?

23. SIGNATURE [illegible] acting Pathologist
M. D. or other
Address Laytonsville Md Date signed 6/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

05171

Reg. Dist. No. 214

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

914 Flower Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 914 Flower Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME RALPH EDWARDS MORRELL, Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Mary Lowe Morrell

6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): Sept 15, 1902

8. AGE: Years: 44 | Months: 9 | Days: 7 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Milford, Texas (Town, county, and state)

10. Usual occupation: Electrician

11. Industry or business:

FATHER

12. Name: Ralph E. Morrell Sr

13. Birthplace: Texas - Milford

MOTHER

14. Maiden name: Mary Alice Smylie

15. Birthplace: Milford, Texas

18. Informant: Mrs. Mary Lowe Morrell

Address: 914 Flower Ave. Tak. Pk. Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof June 25 1947 (month) (day) (year)

Cemetery or crematory: Wash. Natl Cem. Wash. D.C.

Location: Suitland Rd. S.E.

18. Funeral director: W. W. Chambers Co.

Address: 1400 Chapin St. N.W. Wash D.C.

19. June 23 19 47 (Date rec'd by registrar) Josephine M. Schaffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 22 19 47, at 11:35 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 22 19 47, to ..... 19 .....

and that I last saw h..... alive on ....., 19 .....

Immediate cause of death	DURATION
Coronary occlusion	about minutes
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Ernest J. Bronchart M.D. M. D. or other

Address: Gaithersburg Md. Date signed June 23 47

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

05172

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Dyears.
Hospital, Institution, or street address where death occurred:
8910 2nd Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8910 2nd Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ballard Nicholls Morris

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Jeanie Boag Morris
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1863

8. AGE: Years: 84 Months: 2 Days: 0 If less than one day: hrs. min.

9. Birthplace: Nashville, Tennessee
(Town, county, and state)

10. Usual occupation: Patent Attorney (Retired)

11. Industry or business: Law

FATHER
12. Name: William Wolf Morris
13. Birthplace: Delaware

MOTHER
14. Maiden name: Sarah Smith Nichols
15. Birthplace: Washington, D.C.

16. Informant: Mrs Kate Paulina Cannon (Sister)
Address: 3909 53rd Street Bladensburg Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof 6/4/47 (month) (day) (year)
Cemetery or crematory: Gaeche funeral Home
Location: Hyattsville Md

18. Funeral director: E Gaeche sons
Address: Hyattsville Md

19. June 4 19 47 (Date rec'd by registrar) Josephine M Schaeffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 June 19 47, at 1:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 April 19 47, to 4 June 19 47 and that I last saw him alive on 2 June 19 47

Immediate cause of death	DURATION
Congestive Heart Failure.	
Due to: Arterio sclerotic Heart Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Manning H. Alden M. D.
M. D. or other
Address: 8004 Newell Court S. S. Md. Date signed: 4 June 1947.

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

472 05173

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, institution, or street address where death occurred:
4604 Davidson Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4604 Davidson Dr.
(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME WILLIAM BUXTON NEWTON

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Helen C. Newton

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 16, 1873

8. AGE: Years	Months	Days	If less than one day
73	6	8	..... hrs. ..... min.

9. Birthplace Maine
(Town, county, and state)

10. Usual occupation Retired Navy Department

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden name Alice Kenney
15. Birthplace Unknown

16. Informant Mrs. Helen C. Newton
Address 4604 Davidson Dr. Ch. Ch. Md.

17. Cremation Date thereof 6/25/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Maryland

18. Funeral director Wm Reuben Humphrey

Address Bethesda, Maryland

19. 6/25 19 47 [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24, 1947 19 ..... at 2:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 47 to June 25 19 47 and that I last saw h[illegible] alive on June 24th 19 47

	DURATION
Immediate cause of death Cerebral Hemorrhage	2 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE [illegible] M. D. or other

Address 4016 Georgia Ave Date signed 6/25/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

05174

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 21 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 1 month, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1725 N.J.Ave., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: WWI

3.(a) FULL NAME: OLIVER, George Bruce James

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col	separated(18yrs)

6.(b) Name of husband or wife: Mrs. Ruth Oliver
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 18 February 1893

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
54	4	6		

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: unemployed
11. Industry or business

FATHER
12. Name: Enoch Oliver dec.
13. Birthplace: Va.

MOTHER
14. Maiden name: Betty Hoston dec.
15. Birthplace: Va.

16. Informant: sister: Miss Alice Oliver
Address: 1725 N.J. Avenue, N. W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 6-27-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: Melvan & Schey W.E.A.
Address: 424 R St., N. W., Wash., D.C.

19. 6-25 1947 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 June 1947 at 9:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 1947 to June 24 1947 and that I last saw him alive on 24 June 1947

Immediate cause of death: CEREBRAL EMBOLI WITH ENCEPHALOMALACIA; PULMONARY EDEMA — DURATION

Due to: SYPHILITIC AORTITIS AND SACCULAR ANEURYSM OF INNOMINATE ARTERY WITH MURAL THROMBUS

Other conditions: MULTIPLE CEREBRAL EMBOLI; CONGESTIVE HEART DISEASE
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: (SAME AS ABOVE)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. B. Bryan
J. B. BRYAN, Lt.(jg) (MC) USNR
M. D. or other
Address: USNH Bethesda, Md. Date signed: 6-25-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2/16/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

05175

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? few hours
Hospital, institution, or street address where death occurred:
Kenwood Country Club
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda 14,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9610 Wilson Lane
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II

3.(a) FULL NAME: Burton E. Palmer

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Helen Root Palmer
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): October 11, 1903

8. AGE: Years	Months	Days	If less than one day
43 43	8	4	... hrs. ... min.

9. Birthplace: Missoula, Montana
(Town, county, and state)

10. Usual occupation: Consultant

11. Industry or business: Civil Service Commission

FATHER
12. Name: Bertram Palmer
13. Birthplace: Utah

MOTHER
14. Maiden name: Minnie Smithson
15. Birthplace: Utah

16. Informant: Helen Root Palmer (wife)
Address: Bethesda, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 17, 1947 (month) (day) (year)
Cemetery or crematory: Arlington Nat'n. Cemetery
Location: Arlington, Virginia

18. Funeral director: Wm. Reuben Pumphrey
Address: Bethesda, Maryland

19. 6/16/1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 15 1947, at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. Med. Exam 19..., to ... 19...
and that I last saw h... alive on Exam case 19...

Immediate cause of death	DURATION
Coronary occlusion	died suddenly while playing tennis
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Frank J. Broschart M.D. M. D. or other
Sept. Med. Exam.
Address: Gaithersburg, Md. Date signed: 6-15-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05176

95C

CERTIFICATE OF DEATH

Reg. Dist. No. 7-13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Montgomery

City or town Martinsburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State Maryland County Montgomery

City or town Martinsburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Norwood H. Palmer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Colored	Married

6.(b) Name of husband or wife Esther Palmer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1887

8. AGE: Years 59 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Harrison Palmer

13. Birthplace Md.

MOTHER 14. Maiden name Henrietta

15. Birthplace Md.

16. Informant Esther Palmer (wife)

Address Martinsburg, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof June 8, 1947 (month) (day) (year)

Cemetery or crematory Martinsburg

Location Martinsburg, Md.

18. Funeral director Robert L. Snowden

Address Rockville, Md.

19. June 8 1947 (Date rec'd by registrar) Mrs. E. P. Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 19 47, at 1:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam 19 ..... to ..... 19 ..... and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Uremia	3 days
Due to Chronic heart & kidney disease	6 mos.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Frank J. Bouchart M.D. Dep. Med. Exam. M. D. or other

Address Martinsburg, Md. Date signed 6-9-47

05177

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 52b

CERTIFICATE OF DEATH

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 days

Hospital, Institution, or street address where death occurred:

Washington Sanitarium

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Silver Springs

(If outside city or town limits, write RURAL and give nearest town)

Street No. 737 Easley St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ora Etta Paxson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife Walter Paxson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 23 1873

8. AGE: Years	Months	Days	If less than one day
73	11	2	..... hrs. ..... min.

9. Birthplace Loudon Co. Va.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Thomas Moran

13. Birthplace Virginia

MOTHER 14. Maiden name Frances Moran

15. Birthplace Loudon Co. Virginia

16. Informant Washington Sanitarium Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 25 1947 (month) (day) (year)

Cemetery or crematory Addison Chapel

Location East Pleasant Md.

18. Funeral director D. W. Chamber Co.

Address Forestville Md.

19. June 23 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23, 1947 at 9:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 22 1947 to June 23 1947 and that I last saw h.. alive on June 23, 1947

Immediate cause of death	DURATION
Carcinoma of Bladder	
Due to	
Due to	
Other conditions Melaena	

(Include pregnancy within 3 months of death)

Major findings of operation Ca of Bladder

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Oliver E. Thompson M. D. or other

Address 1323 New Hamp. Date signed 6/23/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

163C

05178

CERTIFICATE OF DEATH

Reg. Dist. No. 229

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2½ days

Hospital, institution, or street address where death occurred:

Washington Sanitarium

How long in hospital or institution? 2½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Virginia County:

City or town: Arlington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3731 S. 4 Mile Run Drive

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs Rose Pentansky

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Separated

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ? 1887

8. AGE: Years: 60 Months: Days: If less than one day: hrs. min.

9. Birthplace: Russia

(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business:

FATHER

12. Name: Daniel Frankman

13. Birthplace: Russia

MOTHER

14. Maiden name: Eva (?)

15. Birthplace: Russia

16. Informant: Hospital Records

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 27-947 (month) (day) (year)

Cemetery or crematory: Bray Grall Cem

Location: Glen Echo Md.

18. Funeral director: B Danzansky & Son

Address: 3501-14th St N W

19. June 26 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26 19 47 at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 Med Exam Camp 19 to 19 and that I last saw h alive on 19

Immediate cause of death	DURATION
Lysol Poisoning	3 days
Due to: Suicide	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: suicide Date of 6-23-47

Where did injury occur? Silver Spring (City or town) Montg. (County) Md. (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Bosckart M.D. M. D. or other

Address: Gaithersburg Md. Date signed 6-26-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05179

94a

CERTIFICATE OF DEATH

Reg. Diat. No. 212

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County Montgomery

City or town Poolesville RFD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 72

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montg

City or town Poolesville, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sarah Agnes Poole

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife Charles Poole

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2 - 1875

8. AGE:

Years	Months	Days	If less than one day
72	3	1	hrs. min.

9. Birthplace Poolesville, Montg Co. Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name James Beall

13. Birthplace Poolesville, Md

MOTHER

14. Maiden name Sarah Merchant

15. Birthplace Maryland

16. Informant Frank Poole

Address Poolesville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-5-47 (month) (day) (year)

Cemetery or crematory Monocacy

Location Beallsville, Md

18. Funeral director William B. Hilton

Address Barnesville, Md

19. June 4 1947 (Date rec'd by registrar) Mrs. C. C. Hilton By Mrs. W. B. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1947 at 11:00 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 2nd 1946 to 19

and that I last saw h alive on 19

Immediate cause of death

Coronary occlusion — DURATION: 2 hours

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE Frank J. Bouchat M.D. M. D. or other

Address Barnesville Md Date signed 6-3-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95C

05180

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 6-23-'47-8 P.M.

Hospital, Institution, or street address where death occurred:

8600 Old Georgetown Rd. Bethesda Md.

How long in hospital or institution? Since 6-23-'47

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda 14,

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5517 Northfield Rd. Bethesda

(If rural, give LOCATION)

2.(a) Ever in U. S. Armed Forces? None

3.(a) FULL NAME Mr Alfred W. Probst

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Mary E. Probst (Deceased)

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) JUNE 10, 1866

8. AGE: Years	Months	Days	If less than one day
81	0	14	— hrs. — min.

9. Birthplace Lock Haven Pennsylvania (Town, county, and state)

10. Usual occupation Retired

11. Industry or business Clothing Designer

FATHER 12. Name UNKNOWN

13. Birthplace UNKNOWN

MOTHER 14. Maiden name UNKNOWN

15. Birthplace UNKNOWN

16. Informant MRS. Edna P. Chester

Address 5517 Northfield Rd., Bethesda, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 6/25/47 (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Maryland

18. Funeral director Wm. Rankin Humphrey

Address Bethesda, Maryland

19. 6/25 1947 (Date received by registrar) Mrs. E. Jones

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-24 1947 at 12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 1947, to June 24 1947 and that I last saw h. alive on June 24 1947

Immediate cause of death	DURATION
Peritonitis	4 days
Due to Ruptured placentes and pericondrites	2 wks.
Due to Cardiac decompensation	4 Days
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____

Autopsy results Confirmation above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE Edward H. Hurley M. D. or other

Address 1726 Eye St. N. W. Washington 6 Date signed 6/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46g CB 05181

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 days

Hospital, institution, or street address where death occurred: Washington San. + Hospital, Takoma Park, Md.

How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 238 Maryland Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Read, Mrs. Jane T.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow.

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 26, 1872

8. AGE: Years	Months	Days	If less than one day
75	3	23	hrs. min.

9. Birthplace: Scotland (Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business:

FATHER — 12. Name: Henry Taylor

13. Birthplace: England

MOTHER — 14. Maiden name: Janet Brown

15. Birthplace: Scotland

16. Informant: Wash. San + Hosp. Records Address: Wash. San. + Hosp.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: June 18-1947 (month) (day) (year)

Cemetery or crematory:

Location: Washington D.C.

18. Funeral director: J. Wm. Lee Sons Co. Address: 300 - 4th St. N.W. Washington D.C.

19. June 18 1947 (Date rec'd by registrar) J. Wm. Lee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18 1947, at 6:23 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/28 1947, to 6/17 1947, and that I last saw her alive on 6/17/47 1947

Immediate cause of death	DURATION
Carcinoma Head of Pancreas	
Due to:	
Due to:	
Other conditions: Obstructive Jaundice	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Geo. H. Holden M. D. or other

Address: 500 Rhode Island Ave. N.W. Date signed: 6/18/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

106 b

CD 05182

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days, 6 hours
Hospital, Institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 2 days, 6 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Dist. of Col. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3900 14th St., N.W. Apt. 310
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MRS. EDNA MARIE ROACH

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife: DR. EDWARD J. ROACH
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 1, 1891

8. AGE: Years 55 | Months 6 | Days 12 | If less than one day: hrs. min.

9. Birthplace: Sullivan, Indiana
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Woodfurt Woods
13. Birthplace: Indiana

MOTHER
14. Maiden name: Catherine Eaton
15. Birthplace: Indiana

16. Informant: SUBURBAN HOSPITAL RECORDS
Address:

17. Burial, ~~Cremation~~, or removal. Which? Burial
Date thereof: June 16 47 (month) (day) (year)
Cemetery or crematory: St. Joseph's Cemetery
Location: Cincinnati, Ohio

18. Funeral director: Francis Collins
Address: 3821-14th St. N.W. Wash. D.C.

19. 6/13/47 (Date rec'd by registrar)
Wm E. Jolly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 13, 1947 at 2:17 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1946 to 13 June 1947 and that I last saw h[illegible] alive on 13 June 1947.

Immediate cause of death	DURATION
Bronchial asthma	35 yrs.
Due to: —	
Due to: —	
Other conditions 1. Bronchiectasis rt. upper lobe.	3 yrs.
2. Arteriosclerosis moderate	indef.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: See above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Joseph Kovacs M.D.
M. D. or other
Address: 6318 16th St. Silv. Spg. Md. Date signed: 13 June 47

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05183

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 7/6

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda Suburban Hospital
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Kensington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3400 Fernside Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME SAMUEL ROSE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Deceased 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 24, 1873

8. AGE:

Years	Months	Days	If less than one day
74	4	8	hrs. min.

9. Birthplace England (Town, county, and state)
10. Usual occupation Retired
11. Industry or business ?

FATHER
12. Name John Rose
13. Birthplace England

MOTHER
14. Maiden name Elizabeth Cordingley
15. Birthplace England

16. Informant Mrs. Edith Rose Myer
Address 407 N. Piedmont St. Ell. Va.

17. Cremation Date thereof June 4, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rock Hill Cemetery
Location Pa. Ave. S.E. Wash. D.C.

18. Funeral director J. Arthur Walters
Address 254 Carroll St. Takoma Park. D.C.

19. 6/7 1947 Wm E. Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1947 at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/24/47 19 to June 2 1947 19
and that I last saw h alive on 19

	DURATION
Immediate cause of death Uraemia	3 days
Underlying cause: Nephrosclerosis, severe, chronic, cause undetermined (?) (3/24/47 also)	
Due to 1. Arteriosclerosis Generalized	5-10 yrs.
2. Hypertension, Severe	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Sam Allen M.D.
M. D. or other
Address Kensington Date signed 6/2/47

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92b

05184

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 507 Carroll Ave, Takoma Park, Md.
How long in hospital or institution? 5 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Takoma Park Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 507 Carroll Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: ELIZABETH M. SAFFORD

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6.(b) Name of husband or wife: Hiram Sprague Safford
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 17 1841

8. AGE: Years	Months	Days	If less than one day
105	7	6	..... hrs. ..... min.

9. Birthplace: Washington, D C
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: William McTeak.
13. Birthplace: On the Ocean

MOTHER
14. Maiden name: Mary White Cock
15. Birthplace: Ireland

16. Informant: Miss Clara L. Safford
Address: 807 Maple Ave Takoma Park Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: June 25 1947 (month) (day) (year)
Cemetery or crematory: J. Williams Leis Sons Co
Location: Washington D C

18. Funeral director: J. Williams Leis Sons Co
Address: 306 - 4 St N.E. Washington D C

19. June 24 19 47 (Date rec'd by registrar) J. Wilson Wolff Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 23 June 1947 at 11 55 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 Sept. 1946 1946 to 23 June 1947
and that I last saw her alive on 14 June 1947

Immediate cause of death	DURATION
Gangrene Left foot and leg	12 days.
Due to Arteriosclerosis Generalized	20-25 years
Due to Senility	
Other conditions Mitral stenosis and insufficiency	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: G B Queen M.D.
M. D. or other
Address: 112 Willow Ave Takoma Park Date signed: 24 June 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH K
2411 N. Charles St., Baltimore 53

CERTIFICATE OF DEATH

05185

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
1012 Woodside Parkway

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1012 Woodside Parkway
(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME ELIZABETH W. SMITH

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife John E. Smith, Jr.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 19th. 1914

8. AGE: Years	Months	Days	If less than one day
32	6	8	..... hrs. ..... min.

9. Birthplace Ontario, Canada
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Fred Bragge

13. Birthplace Newcastle, England

MOTHER 14. Maiden name Sarah Neilson

15. Birthplace England

16. Informant Mr. John E. Smith, Jr.

Address 1012 Woodside Parkway

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-1-1947 (month) (day) (year)

Cemetery Arlington National

Location Arlington Co. Va.

18. Funeral director Maurice E. Pumphrey

Address Silver Spring, Md.

19. June 30 1947 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1947, at 9:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1947, to June 27 1947

and that I last saw h[illegible] alive on June 27 1947

Immediate cause of death	DURATION
Cardiac failure	3 da.
Due to malignant melanoma left wrist	18 mo.
Due to metastasis to ribs, left femur, rt. breast & dorsal Spine	18 mo.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation malignant melanoma Date of op. Dec. 1945

Autopsy results not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Frank G. Zack M.D. M. D. or other

Address 8248 Ga. Ave. Silver Spring Md. Date signed 6-28-47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

05186

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:

County 109- East Indian Spring Dr.

City or town Silver Spring, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County Montgomery

City or town Silver Sp. Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 109 East Indian Sp. Dr.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Fannie M. Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 23- 1876

8. AGE: Years	Months	Days	If less than one day
70			hrs. min.

9. Birthplace Cumberland Co. Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name William D. Walker

13. Birthplace Va

MOTHER

14. Maiden name Ellen M. Crowdon

15. Birthplace Cumberland, Co., Va.

16. Informant Mrs Robert S. Floyd

Address 109 E. Indian Sp Dr.

17. Burial Removal Date thereof June 17 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Methodist Church Cem

Location Farmville, Va.

18. Funeral director The D. W. Hines Co

Address 2901-14 st n.w.

19. June 17 1947 Josephine M. Schaffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1947 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 1947 to 1947

and that I last saw h alive on June 16 1947

Immediate cause of death	DURATION
Coronary Embolism	1 hr
Due to, Coronary Thrombosis	8 dys
Due to, Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wesley Long M.D.
M. D. or other

Address Silver Spring Md Date signed June 17 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05187

92d

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:

County: Montg Co,

City or town: Gaithersburg Md, Rural.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1yr 3Mo

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Virginia County:

City or town: Lovettsville.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Laura Jane Spring

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Wm C, Spring

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 3rd 1853

8. AGE: Years	Months	Days	If less than one day
1853 94	1	10	hrs. min.

9. Birthplace: Lovettsville, Va,
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: "

FATHER
12. Name: Elias Spring
13. Birthplace: Va,

MOTHER
14. Maiden name: Mary E, Stonebaker
15. Birthplace: Va,

16. Informant: Nona Demery

Address: Gaithersburg Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/15/47 (month) (day) (year)

Cemetery or crematory: Lovettsville. Cemetery

Location: Lovettsville. Va,

18. Funeral director: Renice E. Brown

Address: Lovettsville, Va,

19. June 14 1947 (Date rec'd by registrar) Almeda L Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 13th 1947 at 12 Noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1947 to June 13 1947

and that I last saw h[illegible] alive on June 12 1947

Immediate cause of death	DURATION
Acute Cardiac Dilatation	1 hr
Due to: Chronic valvular heart disease	2 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Fred J. Brashears M.D.
M. D. or other

Address: Gaithersburg Md Date signed 6-13-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The street age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05188

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 minutes

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 45 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Ohio County:

City or town: E. Cleveland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1315 E. 143rd Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW1 & WW 2

3.(a) FULL NAME: STRONG, Harry Elmer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 30 September 1893

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
53	8	16		

9. Birthplace: Ohio
(Town, county, and state)

10. Usual occupation: Arlington Police Dept.

11. Industry or business: Falls Chruch, Va.

FATHER
12. Name: Ralph W. Strong
13. Birthplace: Ohio

MOTHER
14. Maiden name: Weltha French dec.
15. Birthplace: Ohio

16. Informant: Father: Mr. Ralph W. Strong
Address: 1315 E. 143rd St., E. Cleveland, Ohio

17. burial — Date thereof: 6-19-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: IVES FUNERAL HOME

Address: 2847 Wilson Blvd., Arlington, Va.

19. 6-17 1947 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 16 June 1947, at 2 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 16 June 1947, to 16 June 1947 and that I last saw him alive on 16 June 1947

Immediate cause of death	DURATION
MYOCARDIAL INFARCTION, RECENT	
Due to CORONARY THROMBOSIS, RECENT and OLD	
Due to CORONARY ARTERIOSCLEROSIS	ca 1 year
Other conditions CONGESTIVE HEART FAILURE and ARTERIOSCLEROSIS	

(Include pregnancy within 3 months of death)

Major findings at operations:

Date of op.:

Autopsy results: (same as above)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. B. Bryan
J. B. BRYAN, Lt.(jg)(MC) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 6-16-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct and legible. Age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

6/27/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a 05189

CERTIFICATE OF DEATH

Reg. Diat. No. 218

1. PLACE OF DEATH:
County: Montg Co,
City or town: Gaithersburg Md, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 Days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Va, County:
City or town: Warrenton.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mary Virginia Taylor

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Wm F, Taylar
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 22 1881

8. AGE: Years	Months	Days	If less than one day
65	6	10	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business: "

FATHER
12. Name: Buck Wines
13. Birthplace: Va,

MOTHER
14. Maiden name: Mary Wines
15. Birthplace: Va,

16. Informant: Mrs J L, Wines
Address: Gaithersgburg, Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6/5/47 (month) (day) (year)
Cemetery or crematory: Warrenton Cemetery
Location: Warrenton Va,

18. Funeral director: Ernest C, Gartner
Address: Gaithersburg. Md,

19. June 7 1947 Abudal G Brooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 2nd 1947, at 4.50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 14 1947, to June 1 1947
and that I last saw h~~e~~ alive on June 1 1947

Immediate cause of death	DURATION
Cerebral Hemmorhage	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Gaithersburg Md Date signed: June 3/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05190

94a

CERTIFICATE OF DEATH

Reg. Diat. No. 213

1. PLACE OF DEATH:

County: Moulgomery

City or town: Halpine - Rural R-7 Rockville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death: 5 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Moulgomery

City or town: Halpine - Rural R-7 Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R-7 D#2 - Rockville

(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME: Robert Roy Tedder Tedder

3.(b) Social Security Number: 213-12-1210

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Rebecca Lo. Tedder

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): February 15-1911

8. AGE:

Years	Months	Days	If less than one day
36	3	21	..... hrs. ..... min.

9. Birthplace: Sparta - North Carolina (Town, county, and state)

10. Usual occupation: Investigator

11. Industry or business: Phil Gas Company

FATHER

12. Name: Ellis Lo. Tedder

13. Birthplace: Sparta - North Carolina

MOTHER

14. Maiden name: Elora Richardson

15. Birthplace: Sparta North Carolina

16. Informant: Rebecca Lo. Tedder

Address: R.F.D #2 - Rockville - Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 9 '47 (Month) (day) (year)

Cemetery or crematory: Arlington Natl Cemetery

Location: Arlington Co - Virginia

18. Funeral director: Wm. Reuben Funeral Service

Address: Rockville - Maryland

19. June 8 1947 (Date rec'd by registrar) Mrs. E. P. Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 June 1947 at 6:45 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 Jan. 1947 to 6 June 1947 and that I last saw him alive on 6 June 1947

Immediate cause of death	DURATION
Coronary Thrombus	1 hr
Due to: Coronary Sclerosis	5 mons
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W S Murphy M.D. M. D. or other

Address: Rockville Md Date signed: 7 June '47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

05191

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH:

County: Montgomery

City or town: DAMASCUS

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1/2 yes.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: Montgomery

City or town: DAMASCUS

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: ANNA Cummings Thatcher

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: David C Thatcher

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 18, 1861

8. AGE: Years	Months	Days	If less than one day
85	10	18	..... hrs. ..... min.

9. Birthplace: Guildhall, Vermont (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER — 12. Name: Isaac Cummings

FATHER — 13. Birthplace: Topsfield, Mass.

MOTHER — 14. Maiden name: Hanna Young

MOTHER — 15. Birthplace: New Hampshire

16. Informant: Mr. Mark G. Thatcher

Address: DAMASCUS, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 8 1947 (month) (day) (year)

Cemetery or crematory: Methodist

Location: Northfield Falls, Vt.

18. Funeral director: J B Beall Inc.

Address: DAMASCUS, Md.

19. June 6 1947 (Date rec'd by registrar) Della V Burdett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6 1947, at 12:16 A: M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17 1946 to June 6 1947

and that I last saw h FR alive on June 5 1947

Immediate cause of death: Cerebral thrombosis — DURATION: 1 week.

Due to: Arteriosclerotic cardiovascular disease. — 15 years

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James F. Kerr M.D. M. D. or other

Address: Damascus, Md. Date signed: June 6, 1947

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

05192

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Indian Head
(If outside city or town limits, write RURAL and give nearest town)
Street No. 18 West Patton Road
(If rural, give LOCATION)
2.(a) If veteran, name war: SpAm.

3.(a) FULL NAME: TORRENS, Francis Aloyisus

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Angela Torrens
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 15, 1880

8. AGE: Years	Months	Days	If less than one day
67	1	6	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: unknown

11. Industry or business

FATHER
12. Name: Torrens, John
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: wife: Mrs. Angela Torrens
Address: 18 West Patton Road, Indian Head, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 6-24-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: P. A. TALTAVULL W.W Taltavull
Address: 3619 14th St., NW, Washington, D.C.

19. 6-22 1947 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21 1947, at 4:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 June 1947 to 21 June 1947 and that I last saw him alive on 21 June 1947

Immediate cause of death	DURATION
CORONARY THROMBOSIS and MYOCARDIAL INFARCTION	3-4 days
Due to: ARTERIOSCLEROSIS	2 years
Due to:	
Other conditions: CONGESTIVE HEART FAILURE	3-4 days

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: SAME AS ABOVE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. B. Bryan J. B. BRYAN, Lt. (jg) MC USNR
M. D. or other
Address: USNH Bethesda, Md. Date signed: 6-22-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

4/29/47

Mrs Lawler

05193

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:
County Montgomery
City or town Olney, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
The Montgomery County General Hospital
How long in hospital or institution? 4 hours 40 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Berwyn
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rayburn Club.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Garfield Turner

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married.

6.(b) Name of husband or wife Mary Turner
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
65			4 hrs. 40 min.

9. Birthplace Amherst, Virginia
(Town, county, and state)
10. Usual occupation Porter
11. Industry or business

FATHER
12. Name Andrew Turner
13. Birthplace Va.

MOTHER
14. Maiden name Hannah
15. Birthplace Va

16. Informant Hospital records
Address Burial Removal
17. (Burial, cremation, or removal. Which?) Date thereof June 8th 1947 (month) (day) (year)
Cemetery or crematory
Location Covington, Virginia
18. Funeral director Quigley Funeral Home
Address 389 R. D. A.C. H.W. Wash. D.C.
19. June 3 1947 (Date rec'd by registrar) Gertrude R. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1947, at 5 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3 1947, to June 3 1947
and that I last saw h/im alive on June 3 1947

Immediate cause of death	DURATION
Pulmonary infarction	2 days
Due to	
Due to	
Other conditions Arteriosclerotic Heart Disease, Cardiac insufficiency	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE J. W. Bird M. D. or other
Address Sandy Spring, Md. Date signed 6/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

05194

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH

County Montgomery. Registration Dist. No. 216

Village or City Bethesda, No. 4800 Old Georgetown Rd. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. if of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Hilda A. VINCENT

(a) Residence: No. 1224-13th St., N.W. Ward. Washington D.C.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	MARRIED

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of William L. VINCENT

6. DATE OF BIRTH (month, day, and year) FEB. 2, 1910

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37			

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Sydney, Nova Scotia

FATHER

13. NAME John Southerland

14. BIRTHPLACE (city or town) (State or country) Sydney, Nova Scotia

MOTHER

15. MAIDEN NAME Ann Mc Dougal

16. BIRTHPLACE (city or town) (State or country) Sydney, Nova Scotia

17. INFORMANT Husband - William L. VINCENT
(Address) 1224 - 13th St N.W. Wash. D.C.

18. BURIAL, CREMATION, OR REMOVAL
Place Nash. Nat. Cem. Date 6/21, 1947

19. UNDERTAKER W. W. Chambers Co.
(Address) 1400 Chapin St. N.W.

20. FILED 6/20, 1947 Wm E. Jolley
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH June 19, 1947
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from February 7, 1947, to June 19, 1947

I last saw her alive on June 19, 1947; death is said to have occurred on the date stated above, at 6:15 P.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Generalized abdominal and pelvic carcinomatosis with spontaneous colostomy (erosive).	
Cachexia.	
Primary site of carcinoma:	

Other Contributory Causes of importance: Carcinoma of Cervix, Squamous Cell, Grade III [illegible]

Name of operation Total hysterectomy Date of May, 1946.

Whether confirmed diagnosis? Path. section Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury ..., 19...

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) E. A. Krause M. D.

(Address) 3005 McKinley St. N.W. Wash. D.C.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

05195

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

186a CB

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING (I)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M 7/5/47

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 hours

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 12 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Ark. County:

City or town: Redfield
(If outside city or town limits, write RURAL and give nearest town)

Street No.: C/o Joe K. Hipp
(If rural, give LOCATION)

2.(a) If veteran, name war: 2nd WW

3.(a) FULL NAME: WALKER, John Leroy

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Teopal Mae Walker

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 2, 1918

8. AGE:

Years	Months	Days	If less than one day
29	0	23	hrs. min.

9. Birthplace: Georgia
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business

FATHER
12. Name: John H. Walker dec.
13. Birthplace: Ga.

MOTHER
14. Maiden name: Blanchie Pace
15. Birthplace: Fla.

16. Informant: wife: Mrs. Theopal Mae Walker
Address: c/o Joe K. Hipp, Redfield, Ark.

17. removal (Burial, cremation, or removal. Which?) Date thereof: 6-26-47 (month) (day) (year)

Cemetery or crematory:

Location: Plant City, Fla.

18. Funeral director: W. W. CHAMBERS

Address: 1100 Chapin St., N. W., Wash., D.C.

19. 6-25 19 47 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 25 19 47 at 12:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dec. Med. Exam 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Massive pulmonary collapse + hemorrhage	12 hrs.
Due to Post traumatic psychosis	3 days
Due to Contusion of left orbital area (accidental)	
Due to	
Other conditions Laceration of neck (self inflicted)	12 hrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accidental Date of 6-24-47

Where did injury occur? Washington DC
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: fall Injured at work?

23. SIGNATURE: Frank J. Bosshart M.D.
Dec. Med. Exam
M. D. or other

Address: Gaithersburg Md Date signed: 6-26-47

05196

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs.
Hospital, institution, or street address where death occurred:
4608 Walsh Street
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4608 Walsh Street,
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: ANNIE M. WARD

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Stephen P. Ward (deceased)
6.(c) If alive, give age: ..... years
7. Birth date of deceased (mo., day, yr.): Jan. 1, 1864

8. AGE: Years	Months	Days	If less than one day
83	5	3	— hrs. — min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: Olando Burton
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Orvilla DeVoe
15. Birthplace: Pottersville, Maryland

16. Informant: Mrs. Lillian W. Snapp (daughter)
Address: Chevy Chase, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/7/47 (month) (day) (year)
Cemetery or crematory: Louden Park, Baltimore
Location: Maryland
18. Funeral director: W. Reuben Humphreys
Address: Bethesda, Maryland

19. 6/4 1947 (Date rec'd by registrar) Wm E Jules Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4, 1947, at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940 to June 4 1947 and that I last saw h[illegible] alive on June 3 1947

Immediate cause of death	DURATION
Coronary Thrombosis	3 days
Due to: Coronary Sclerosis	
Due to: Old Age	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: 4016 Chevy Chase Blvd Date signed WI 3790

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05197

97

Reg. Dist. No. 218

1. PLACE OF DEATH:
County Montgomery
City or town Germantown, Md. R-2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Montgomery
City or town Gaithersburg Germantown
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route 2
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Benjamin Wayne

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col	married

6.(b) Name of husband or wife unknown
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) unknown 1862

8. AGE: Years 85 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Fairfax Co., Va.
(Town, county, and state)
10. Usual occupation Truck Gardening
11. Industry or business Vegetable
FATHER 12. Name unknown
13. Birthplace
MOTHER 14. Maiden name Unknown
15. Birthplace
16. Informant Martha Beckwith
Address Germantown, Md. R-2
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 12, 1947 (month) (day) (year)
Cemetery or crematory Union Cemetery
Location Washington, D.C.
18. Funeral director R. L. Snowden
Address Rockville, Md.
19. June 12 1947 (Date rec'd by registrar) Alvada L. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June - 9 - 1947, at 1 P. M.
21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from May - 19 - 1947, to June - 9 - 1947
and that I last saw h.. alive on June 8 - 1947

Immediate cause of death	DURATION
Senile marasmus	3 weeks
Due to Arterio-sclerosis	?
Due to Senile dementia	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE William E. Miller, M.D. M. D. or other
Address Gaithersburg, Md. Date signed 6/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Find correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

05198

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1806 24th St., S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: WEAVER, Jesse Owen, 3rd

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 14, 1947

8. AGE: Years	Months	Days	If less than one day
		5	hrs. min.

9. Birthplace: Bethesda, Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: WEAVER, Jesse
13. Birthplace: Washington, D.C.

MOTHER
14. Maiden name: PIERCE, Mary
15. Birthplace: Washington, D. C.

16. Informant: Mo: Mrs. Mary P. Weaver
Address: 1806 24th St., S.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 6-23-47 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS

Address: 1400 Chapin St., N.W., Wash., D.C.

19. 6-20 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 19 19 47 at 5:15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 14 June 1947 to 19 June 1947 and that I last saw h... im alive on 19 June 1947

Immediate cause of death	DURATION
Asphyxia	
Prematurity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op...

Autopsy results: Ext. inspection & embalming

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did Injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

PAUL PETERSON, Capt.(MC) USN

23. SIGNATURE: M. D. or other

Address: USNH Bethesda, Md. Date signed: 6-20-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

6/26/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05199

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CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: The Montgomery County General Hospital Inc.

How long in hospital or institution? 2 days.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Gaithersburg (If outside city or town limits, write RURAL and give nearest town)

Street No. R #2. Etchison. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Gertrude Weber

3.(b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Norman Weber

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) December 3, 1894

8. AGE: Years 52 Months 6 Days 3 If less than one day ... hrs. ... min.

9. Birthplace Gaithersburg, Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home.

FATHER 12. Name Maurice Bowman

13. Birthplace Montg. Co. Maryland

MOTHER 14. Maiden name Martha Hawkins

15. Birthplace Maryland.

16. Informant Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 8-1947 (month) (day) (year)

Cemetery or crematory Mt Tabor

Location Etchison Md

18. Funeral director Roy W. Barber

Address Laytonsville Md

19. June 8 1947 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6 1947, at 4:47 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3 1947, to June 6 1947 and that I last saw her alive on June 6 1947

Immediate cause of death Intestinal Obstruction — DURATION 5 days

Due to Metastases (abdominal) secondary to melanoma — 9 mos

Due to of scalp + skin surface

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op. —

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Sandy Spring, Md Date signed 6/6/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97

05200

Reg. Diat. No. 223-

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: TAKOMA PARK (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 MONTHS

Hospital, institution, or street address where death occurred: MRS JELLIFFS NURSING HOME

How long in hospital or institution? 3 MONTHS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D. C. County:

City or town: WASHINGTON (If outside city or town limits, write RURAL and give nearest town)

Street No. 4015 16th. AVE. N.W. (If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: MARTHA WEEDON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6.(b) Name of husband or wife: LE POINT

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): AUG. 15, 1863

8. AGE: Years: 83 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: WASH. D. C. (Town, county, and state)

10. Usual occupation: RETIRED

11. Industry or business: D.C. GOV'T.

FATHER — 12. Name: HENRY PUMPHREY

FATHER — 13. Birthplace: D C.

MOTHER — 14. Maiden name: EMMA GATES

MOTHER — 15. Birthplace: D.C.

16. Informant: MRS. EDNA ORR

Address: 148 TODD PL, N.W. WASH. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-4-47 (month) (day) (year)

Cemetery or crematory: Congressional Cemetery

Location: Washington D.C.

18. Funeral director: Francis Scollins

Address: 3821-14th. St. N.W. Washington.

19. June 1 - 1947 (Date rec'd by registrar) J. Wilmer Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 1. 1947, at 5:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4, 1947, to June 1. 1947

and that I last saw h... alive on June 1. 1947

Immediate cause of death: Generalized arteriosclerosis — DURATION: 2-3 years

Due to: —

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. P. Ryland M. D. or other

Address: 4901 Mass Ave N.W. Wash 16 D.C. Date signed: 6-1-47

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

638

05201

CERTIFICATE OF DEATH

Reg. Dist. No. 714

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Good Hope
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DEACEASED:
(For newborn infants give residence of mother)
State: Maryland County: Monty
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Ellen White

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	C	Separated

6.(b) Name of husband or wife: Barney White
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1903 - [illegible] 3

8. AGE: Years	Months	Days	If less than one day
44	4	1	hrs. min.

9. Birthplace: Prince Georges Co. Md. (Town, county, and state)
10. Usual occupation: Practical Nurse
11. Industry or business
FATHER 12. Name: Henry Harrison Thornton
13. Birthplace: Loudon Co. Va.
MOTHER 14. Maiden name: Cora E. Jackson
15. Birthplace: Spencerville Md.
16. Informant: Dorothy Reddix
Address: Good Hope (Sister)
17. Burial, cremation, or removal. Which?: Removal Date thereof: 6/5/47 (month) (day) (year)
Cemetery or crematory:
Location: Removal to Wash. D.C.
18. Funeral director: W. Ernest Garvis Co.
Address: 1432 You St N.W. Wash. D.C.
19. June 5 1947 (Date rec'd by registrar) Joseph M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4 1947, at 1:00 P M

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from February 13 1947, to June 4 1947
and that I last saw h[illegible] alive on June 3 1947

Immediate cause of death	DURATION
Coronary Embolism	1/2 hour
Due to Hypertension	
Cardio-renal Disease	
Due to	
Other conditions Thyrotoxicosis	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Webster Linell M.D.
M. D. or other
Address: Norbeck, Md. Date signed: June 4 20

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164c

05202

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Washington Sanitarium

How long in hospital or institution? 2 hrs 10 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Grant Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Edmund Lewis Windsor

3. (b) Social Security Number

518-07-9065

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Separated.

6.(b) Name of husband or wife: Edna Windsor

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): Sept. 5 1900

8. AGE: Years	Months	Days	If less than one day
46	9	2	...hrs. ...min.

9. Birthplace: Prince George Co. Md.
(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business

FATHER
12. Name: Richard H. Windsor
13. Birthplace: Prince George Co. Md.

MOTHER
14. Maiden name: Rosie Hutchinson
15. Birthplace: Prince George Co. Md.

16. Informant: (Separated) wife. Mrs Edna Windsor
Address: 8857 Piney Branch Takoma Pk. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 9 1947 (month) (day) (year)

Cemetery or crematory: Epiphany Church

Location: Forestville Pr. Geo's Co. Md.

18. Funeral director: Ware & Humphrey

Address: Silver Spring Md.

19. June-10 1947 (Date rec'd by registrar) J. Wilson Dietz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 7 19 47 at 9:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 5 1946 to 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Bullet wound in	
st temple	3 hrs.
Due to: Suicide	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of 6-7-47

Where did injury occur? Takoma Park (City or town) Montg. (County) Md. (State)

Injured at home, farm, industry, public place (where?)

Means of injury 22 rifle Injured at work?

23. SIGNATURE: Frank J. Broschart M.D. Dep. Med. Exam. M. D. or other

Address: Gaithersburg Md. Date signed 6-7-47

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of year of birth and age is shown on G 110 June 16, 1947

05203

50

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 223-

1 PLACE OF DEATH

County Montgomery

Village or City Takoma Park, Md. (No. ___ Wash San & Hospital St.: ___ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mr. James Clarence Wyckoff

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
male	white	Married

6 DATE OF BIRTH July (Month) 6 (Day) 1911 (Year)

7 AGE 35 yrs. 11 mos. 1 ds. If LESS than 1 day ___ hrs. or ___ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry business, or establishment in which employed or (employer): Self

9 BIRTHPLACE (State or country) Burke, Va.

PARENTS

10 NAME OF FATHER Clarence Wyckoff

11 BIRTHPLACE OF FATHER (State or country) Va.

12 MAIDEN NAME OF MOTHER Rosa Rice

13 BIRTHPLACE OF MOTHER (State or Country) Burke, Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Everly Funeral Home By E. F. Patterson

(Address) Fairfax, Va.

15 Filed 6/8 1947 Gertrude Dodd Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 8 (Month) (Day), 1947 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 30, 1947, to June 8, 1947, that I last saw him alive on June 7, 1947, and that death occurred on the date stated above, at ___ m.

The CAUSE OF DEATH* was as follows:

Melanotic Sarcoma
with metastases
(Primary on skin back of ear)
(Duration) ___ yrs. 2 mos. ___ ds.

Contributory Secondary: Mesenteric hemorrhage
(Duration) ___ yrs. ___ mos. 2 ds.

(Signed) Geo. J. Fuller M. D.

June 8 1947 (Address) 125 E. Catherine

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence Fairfax Station, Va.

19 PLACE OF BURIAL OR REMOVAL: National Memorial Park, Falls Church, Va. DATE OF BURIAL: June 10, 1947

20 UNDERTAKER: Everly Funeral Home ADDRESS: Fairfax, Va

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

V. S. No. 1

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia,*" "PUERPERAL *peritonitis,*" *etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed